

3142

CERTIFICATE OF DEATH

Reg. Dist. No.

03130

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>	c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b> <b>32</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Barnes Street</b>		d. STREET ADDRESS <b>Barnes Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>F.</b> Last <b>Bauer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> , Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1898</b> <b>62</b>
9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	11. BIRTHPLACE (State or foreign country) <b>Bel Air, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. Bauer</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Ferry</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.#1</b>	
16. SOCIAL SECURITY NO. <b>215-07-0805</b>		17. INFORMANT (Wife) <b>Mrs. Mary D. Bauer</b> Address <b>Barnes St. Bel Air, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident - hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>general arteriosclerosis -</b> DUE TO (c) <b>essential hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b> <b>adult years</b> <b>10+ years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>old severe myocardial infarction - 10 yrs. ago</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 1961</b> to <b>24 Mar., 1961</b> , that I last saw the deceased alive on <b>11 March, 1961</b> , and that death occurred at <b>4:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Warren R. Lesch, M.D.</b>		ADDRESS (Street, city or town, state) <b>202 S. MAIN - Bel Air, MD</b>	
PHYSICIAN'S NAME (Type) <b>Warren R. Lesch, M.D.</b>		DATE SIGNED <b>3/24/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 27, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>	22d. LOCATION (City, town, or county) (State) <b>Bel Air, Harf. Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>		24a. REC'D BY REGISTRAR <b>W. Broadway &amp; Williams</b> <b>Bel Air, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		DATE <b>MAR 27 '61</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3143

## CERTIFICATE OF DEATH

Reg. Dist. No. 03131

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>21 Walters Road</i>				d. STREET ADDRESS <i>21 Walters Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Bernice Elizabeth Bennett</i>				4. DATE OF DEATH Month <i>March</i> Day <i>17th</i> Year <i>1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/1/1913</i>		9. AGE (In years last birthday) <i>47</i> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>I B M operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HEP. Ind. (Ent.)</i>		11. BIRTHPLACE (State or foreign country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>(Unknown)</i>				14. MOTHER'S MAIDEN NAME <i>(Unknown)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>(Unknown)</i>			
17. INFORMANT <i>Edwin E. Bennett, Edgewood, Md.</i>				Address <i>21 Walters Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of rectum, with</i> <i>154X</i> DUE TO <i>generalized metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>June 5, 1960</i> , to <i>March 15, 1961</i> , that I last saw the deceased alive on <i>March 15, 1961</i> , and that death occurred at <i>11:45 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Romulo V. Goco</i> M.D.				ADDRESS (Street, city or town, state) <i>1800 Freedom Way N</i>			
DATE SIGNED <i>3/18/61</i>							
PHYSICIAN'S NAME (Type) <i>Romulo V. Goco, M.D.</i>				<i>Baltimore 13 Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>3/20/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Andrews Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Wilmington, N.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barry - Aberdeen, Maryland</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 22 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Finner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ARKANSAS STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

DEATH NO. 1

DATE OF DEATH

MEMORIAL

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

3144

03132

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>317 N. STOKES, ST</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH LOUISE BENNETT</b>				4. DATE OF DEATH Month Day Year <b>MAR 14 1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 5, 1903</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CANNING HOUSE</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELMER E. BENNETT</b>				14. MOTHER'S MAIDEN NAME <b>MARYE. GRAY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>ZELMA B. KELLY, HAVRE DE GRACE MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Crown Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 14</b> , 19 <b>61</b> , to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Ruth W. Wadman</b> M.D.				22b. DATE SIGNED <b>3/17/61</b>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS <b>HAVRE DE GRACE MD</b>				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-17-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHARLESTOWN CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>CECIL CO. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b>				25. DATE <b>MAR 20 '61</b>			

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RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3143

## CERTIFICATE OF DEATH

Reg. Dist. No.

03133

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural—Bel Air</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Alms House—Harford Co.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural—Madonna</b>	
3. NAME OF DECEASED (Type or print) First <b>SYLVESTER</b> Middle <b>STREETT</b> Last <b>BILLINGSLEY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1882</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter—retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Perry Hall, Balt. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David S. Billingsley</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Streett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>20-475-755</b>	
17. INFORMANT <b>Mrs. Alma Moore, Fullerton, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive Heart failure (pulmonary Edema)</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Cardio-vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. Bronchial asthma</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1, 1959</b> to <b>March 15, 1961</b> , that I last saw the deceased alive on <b>March 13, 1961</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Willard P. Hudson, M.D.</b> <b>Mar. 15, 1961</b>			
ACTUAL SIGNATURE <b>Willard P. Hudson, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b> <b>Forest Hill, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/18/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillside</b>	22d. LOCATION (City, town, or county) (State) <b>Roslyn Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Rutz</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 20 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Rutz</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2152

11-1-12

Blank lines for recording death certificate information.

Vertical text on the right margin, likely a filing or archival note.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03134											
1. PLACE OF DEATH a. COUNTY <i>Harford</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hanover Trace</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>320 Rogers St.</i>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <i>Aberdeen, Md.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Nicholas J. Bonge</i>						4. DATE OF DEATH <i>March 27 1961</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 17, 1910</i>		9. AGE (In years last birthday) <i>50</i>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Engineer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Engineering</i>				11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis Bonge</i>						14. MOTHER'S MAIDEN NAME <i>Valarie Scorano</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Marie I. Bonge</i> Address <i>320 S. Rogers St. Aberdeen, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Skull</i> 901.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell off ladder</i>							
20c. TIME OF INJURY Month, Day, Year Hour <i>4</i> p.m. <i>3-26-61</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Aberdeen</i> (County) <i>Harford</i> (State) <i>Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Gerald E Palmer</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bettin, Md.</i>				DATE SIGNED <i>3-27-61</i>			
EXAMINER'S NAME (Type) <i>Gerald E Palmer MD</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>3/30/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Gardens, R.D. Aberdeen, Md.</i>		22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR <i>John F. Tarring</i> Address <i>Tarring Funeral Home, Aberdeen, Md.</i>						24a. REC'D BY REGISTRAR <i>APR 3 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>			

04114

(M)

UNITED STATES DEPARTMENT OF COMMERCE  
BUREAU OF ECONOMIC RESEARCH  
WASHINGTON, D. C.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3147

## CERTIFICATE OF DEATH

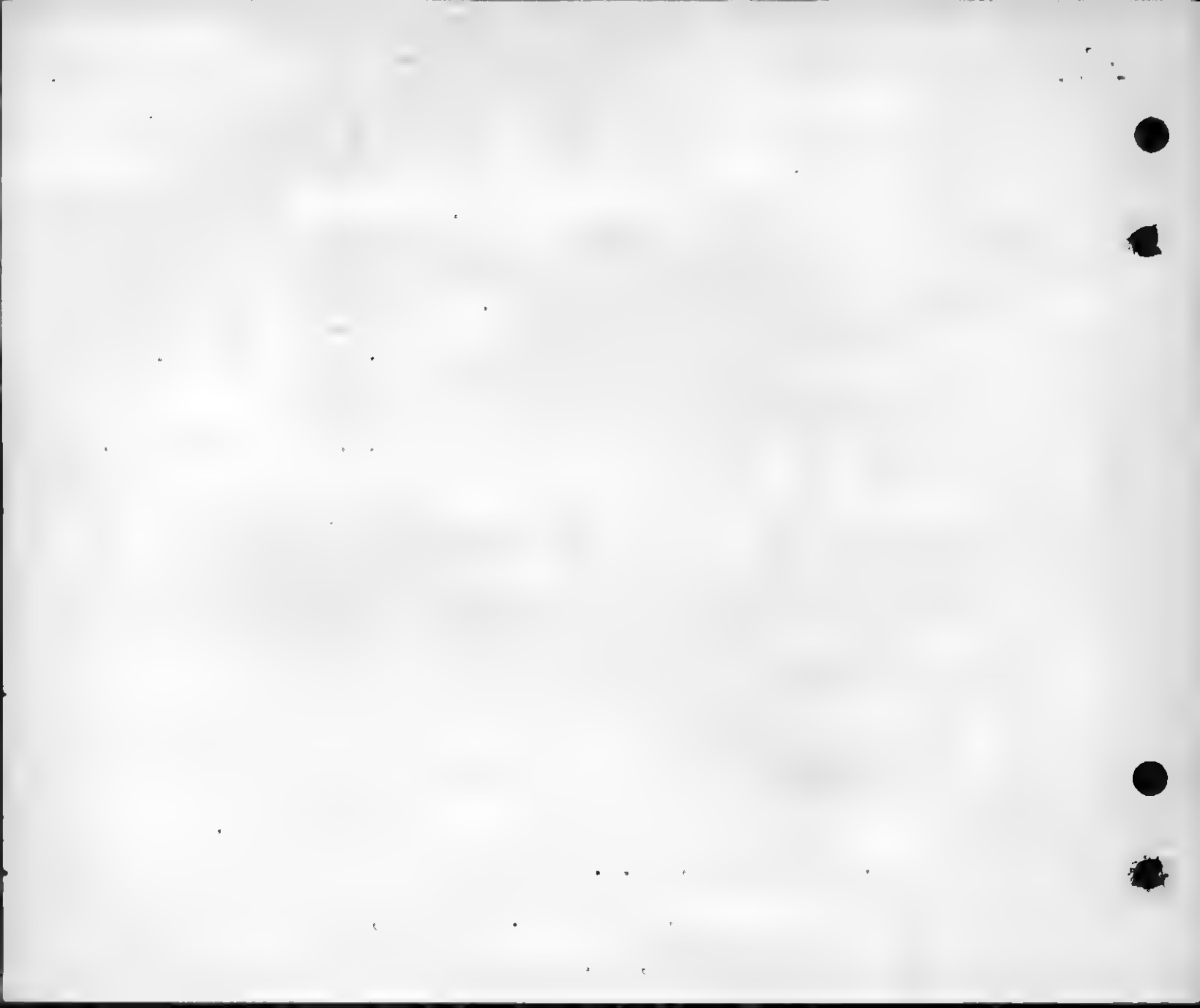
Reg. Dist. No. 03135

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace.</b>		c. LENGTH OF STAY IN 1b <b>7.0 H.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Last <b>BOSTIC</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1899</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Edward Crist</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Kyser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>220-14-2619</b>	
17. INFORMANT <b>Olen Bostic, R.D. 2, Aberdeen, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410X</b> DUE TO <b>Mesenteric Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mitral Stenosis &amp; Decompensat.</b> DUE TO (c) <b>8 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 19 19 61</b> to <b>March 19 61</b> that I last saw the deceased alive on <b>March 19 61</b> and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Ralph Horky</b>		DATE SIGNED <b>Churchville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. Ralph Horky, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/30/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Meth. Cemetery, Norrisville, Maryland</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Tarring</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
ADDRESS <b>Funeral Home Aberdeen, Md.</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO-Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jerusalem Rd</u>		d. STREET ADDRESS <u>1 Jerusalem Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Dudley</u> Middle <u>Bridges</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jerusalem Mills</u>	
11. BIRTH PLACE (State or foreign country) <u>So. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Canada Bridges</u>		14. MOTHER'S MAIDEN NAME <u>Hanna E. Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-6096</u>	
17. INFORMANT <u>Mrs. Elizabeth Ningard</u>		Address <u>Jerusalem Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Stomach</u> DUE TO <u>15 IX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo +</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>60</u> to <u>March</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 10, 1961</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William W. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>3-13-61</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-9-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa (Harford Co.) Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Fun'l Home</u>		24a. REC'D BY REGISTRAR <u>7401 Belvid.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		DATE <u>MAR 17 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be obtained by the hospital or attending physician. It is to be completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 3149 CERTIFICATE OF DEATH

03137

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARFORD</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL HAVERDE GRACE</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CE. MARYLAND AVE. + LYONS ST.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if last 1st on residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL HAVERDE GRACE</u> d. STREET ADDRESS <u>MARYLAND AVE + LYONS ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>AMY HALL BROWN</u> First Middle Last <b>4. DATE OF DEATH</b> <u>MARCH 29 1961</u> Month Day Year		<b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>FEBRUARY 12, 1885</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Yrs.	
<b>9. AGE</b> (In years last birthday) <u>76</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RETIRED</u> <b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>CHARLES TAYLOR WILSON</u> <b>14. MOTHER'S MARRIED NAME</b> <u>SERENA BATEMAN</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>—</u> <b>17. INFORMANT</b> <u>ALICE B. REASIN HAVERDE GRACE HEIGHTS MD.</u> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>331X</u> DUE TO <u>Cerebral Vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Generalized Cerebrovascular</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>64 YEARS</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 4 3, 1955</u> <b>to</b> <u>March 29, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 26, 1961</u> , <b>and that death occurred at</b> <u>10:45 PM</u> , <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>Dudley Phillips MD</u> <b>22b. DATE SIGNED</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dudley Phillips MD</u> <b>22d. ADDRESS</b> <u>DARLINGTON, MARYLAND</u>			
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> <u>BURIAL</u> <u>APR 1, 1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Angel Hill Cem</u> <b>23d. LOCATION (City, town or county)</b> <u>HAVERDE GRACE MD</u> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. Madison Mitchell</u> <b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Hines</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>—</u> <b>DATE</b> <u>APR 4 '61</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03138

3150

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford County Home, Bel Air, Md.</u>		d. STREET ADDRESS <u>Havre de Grace</u> <u>24</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Earl</u> Last <u>Bryant</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bryant</u>		14. MOTHER'S MOLDEN NAME <u>Willie Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>---</u>	
17. INFORMANT <u>Edna Marklee = Box 453 - Perryville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (c) <u>Chronic cardio-vascular disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 6, 1956</u> , to <u>March 19, 1961</u> , that I last saw the deceased alive on <u>March 17, 1961</u> , and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Forest Hill, Maryland March 20, 1961</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/27/1961</u>	<u>Westeyan Chapel</u>	<u>Aberdeen, Rural - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrung - Aberdeen, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3151

## CERTIFICATE OF DEATH

Item 26 Film 0282 3/16/61 md

03139

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Res. dence before adm ssion) a. STATE <u>md</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> d. STREET ADDRESS <u>RD 1</u>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Burton</u>		<b>4. DATE OF DEATH</b> Month <u>Mar.</u> Day <u>6</u> Year <u>1961</u>									
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>									
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-7-1894</u>									
<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>									
<b>13. FATHER'S NAME</b> <u>Henry Lockard</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Alexander</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war and dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>192-12-7173</u>									
<b>17. INFORMANT</b> <u>John W Burton Rising Sun R.D. 1 Md.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line 1 (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> (b) <u>Post Anesthesia</u> (c) <u>Opuntal for Cervical Artery</u> PART II. OTHER SIGNIF. CANT. CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....</b> <u>MARCH 6, 1961</u> <b>and that death occurred at</b> <u>3:05 PM</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>M. K. Stender</u>		<b>22b. DATE SIGNED</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>M. K. Stender</u>		<b>22d. ADDRESS</b> <u>Harre de Grace, Md</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-10-1961</u>									
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hopewell</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Port Deposit R.D. Cecil Md</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Grant</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 13 '61</u>									
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>											

TO FUNERAL OR BENDING PHYSICIAN: The law requires that the death certificate be executed within 24 after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HEALTH OFFICER: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (if any) and it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)  
15M 9/60

3152

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03140

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY in lb <b>43mins</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US Army Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>	
3. NAME OF DECEASED (Type or print) <b>DONALD E CURTIS JR</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>March 21, 1961</b>		9. AGE (In years last birthday) <b>43</b> 10. IF UNDER 1 YEAR Months <b>43</b> Days <b>43</b> 11. IF UNDER 24 HRS. Hours <b>43</b> Min. <b>43</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DONALD E CURTIS</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA RODUS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Donald E Curtis (Father) same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Anomaly of Gastrointestinal tract, presumed</b> DUE TO (b) <b>43 Mins</b> DUE TO (c) <b>43 Mins</b>		INTERVAL BETWEEN ONSET AND DEATH <b>43 Mins</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Prematurity</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(Mother)</b> attended the deceased from <b>March 21, 1961</b> to <b>March 21, 1961</b> that (I) <b>last</b> saw the deceased alive on <b>March 21, 1961</b> and that death occurred at <b>7:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Malcolm McLean</b> M.D.		22b. DATE SIGNED <b>March 21, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>MALCOLM MCLEAN Captain, M C</b>		22d. ADDRESS <b>U. S. Army Hospital Aberdeen Proving Ground, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>27 Mar 61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Army Cemetery Center</b>		23d. LOCATION (City, town or county) (State) <b>Edgewood Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John V. Fanning</b>		25a. REC'D BY REGISTRAR <b>APR 3 '61</b>	
ADDRESS <b>Aberdeen Md</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

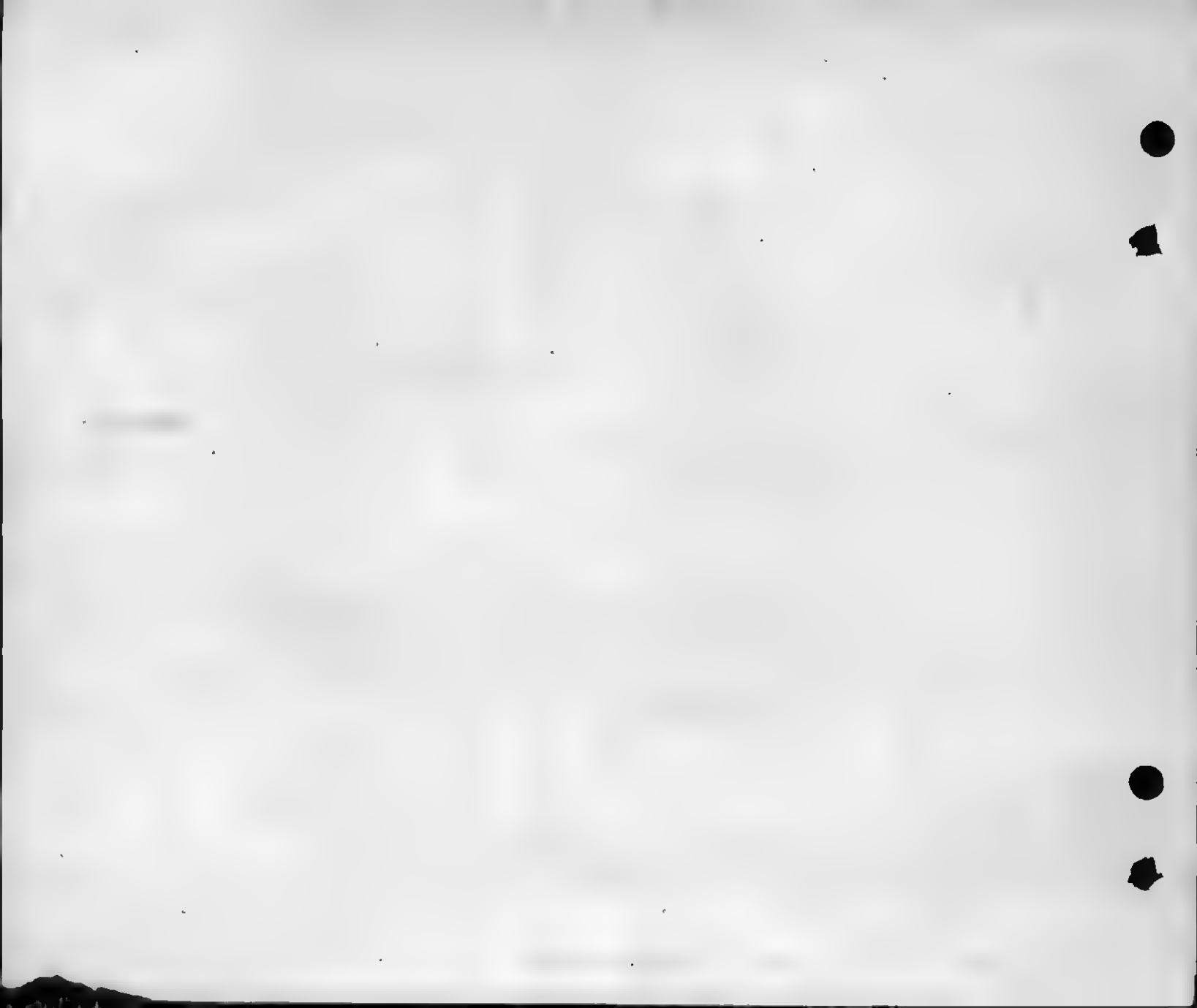
VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03141

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN 1b <u>24</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>625 Ridgewood Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> d. STREET ADDRESS <u>1st Vista Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Christian Carl Dietz</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-14-12</u> 9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>March 2</u> 19 <u>61</u> 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insulating Eng.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Insulating Eng.</u> 13. FATHER'S NAME <u>Christian Dietz</u> 14. MOTHER'S MAIDEN NAME <u>Johanna Hauf</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>212-16-2745</u> 17. INFORMANT <u>Mrs Christian Dietz</u> Address <u>535 Kingsville Rd. t. Vista Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>Bel Air, Md</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-2-61</u>	
ACTUAL SIGNATURE <u>Gerold P Palmer</u> EXAMINER'S NAME (Type) <u>Gerold C Palmer MD</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>3-3-1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Luthern Cem.</u> 22d. LOCATION (City, town, or country) (State) <u>Perry Hall Md.</u>	
23. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u> ADDRESS <u>740 Bel Air Road</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 6 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

03142

1. PLACE OF DEATH  
a. COUNTY Harford MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hampden Beach  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE md b. COUNTY Cecil  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Coloma, Cecil County  
d. STREET ADDRESS 7X-2

3. NAME OF DECEASED (Type or print) Kenneth R. Dinsmore  
First Middle Last  
4. DATE OF DEATH March 12 1961 Month Day Year  
5. SEX M  
6. COLOR OR RACE W  
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH Feb. 17, 1905  
9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder  
10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (State or foreign country) Coloma, md  
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harry Dinsmore  
14. MOTHER'S MAIDEN NAME Mary J. Krauss  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT Frances Dinsmore Address Coloma, md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Rupture intestine  
816 X DUE TO  
Conditions, if any, which gave rise to immediate cause (b)  
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident auto auto type  
20c. TIME OF INJURY Month, Day, Year 3/7- 1961 Hour a.m. p.m.  
20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at 1  
20f. (City or town) (County) (State) Bready Oak Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D. CHIEF MEDICAL EXAMINER ☐ Bel Air, md  
EXAMINER'S NAME (Type) Gerald C Palmer MD ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 3-12-61  
DEPUTY MEDICAL EXAMINER ☒  
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
22b. DATE THEREOF 3/15/1961  
22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery Rising Sun Md  
22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR Ralph M Reed, Rising Sun, md ADDRESS  
24a. REC'D BY REGISTRAR MAR 14 '61 DATE  
24b. REGISTRAR'S SIGNATURE Arthur L. Krauss

MEDICAL CERTIFICATION

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03143

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>HARFORD</b> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b><br>c. LENGTH OF STAY IN 1b <b>10 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD MEMORIAL HOSPITAL</b>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>MARYLAND</b> <b>HARFORD</b><br>f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b><br>g. STREET ADDRESS <b>123 DEEVER ST.</b><br>h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last <b>MARGARET F DRY</b>   |  | <b>4. DATE DEATH</b><br>Month Day Year <b>MARCH 13 1961</b>  |  |
| <b>5. SEX</b> <b>F</b><br><b>6. COLOR OR RACE</b> <b>W</b><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>5/18/1915</b><br><b>9. AGE</b> (In years last birthday) <b>46</b> Yrs.  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>  |  |
| <b>13. FATHER'S NAME</b> <b>WILLIAM FADELEY</b><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)   |  | <b>14. MOTHER'S MAIDEN NAME</b> <b>MARGARET JONES</b><br><b>16. SOCIAL SECURITY NO.</b> <b>123 Deever St.</b><br><b>17. INFORMANT</b> <b>Mrs. Mildred Dry</b>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>171X</b> <b>Chemia -</b><br>DUE TO (b) <b>ureteral obstruction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>adipos carcinoma Cervix stage #4</b><br><b>Primary Secondary Carcinoma</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b><br>Hour a.m. p.m.<br><b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/><br>at work at work<br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>March 3</b> , 1961, to <b>March 13</b> , 1961, that (I) (we) last saw the deceased alive on <b>March 13</b> , 1961, and that death occurred at <b>4:10</b> from the causes and on the date stated above.  |  |  |  |
| <b>22a. SIGNATURE</b><br><b>22c. PHYSICIAN'S NAME</b> (Type) <b>Houng Silva</b>   |  | <b>22b. DATE SIGNED</b><br><b>22d. ADDRESS</b><br><b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>22f. STAFF PHYS.</b> <input checked="" type="checkbox"/>   |  |
| <b>23a. BURIAL</b> (Specify) <b>3/16/61</b><br><b>23b. DATE THEREOF</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Angel Hill</b><br><b>23d. LOCATION</b> (City, town or county) (State) <b>Harford County Md</b>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Pennington</b><br><b>25. REC'D BY REGISTRAR</b> <b>DATE MAR 16 '61</b>   |  | <b>25b. REGISTRAR'S SIGNATURE</b> <b>Hande Hane Md</b>   |  |

TO HOWARD AL OR FUNDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3156

## CERTIFICATE OF DEATH

Reg. Dist. No.

03144

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u> <u>Maryland</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. COUNTY <u>Harford</u> <u>Maryland</u>                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Harde Chase</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Harde Chase Md.</u>  |   |
| c. LENGTH OF STAY IN 1b<br><u>20 yrs.</u>   |   | d. STREET ADDRESS<br><u>300 S. Union Ave.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Genevieve Mary Canahan</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>3/21/61</u><br><u>19</u>   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12/38/1896</u>   |
| 9. AGE (In years last birthday)<br><u>64</u> yrs.   |   | IF UNDER 1 YEAR: IF UNDER 24 HRS<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Bernard Glancy</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Tohey</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>no</u>  |   | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>   |   |
| 17. INFORMANT<br><u>J. J. Canahan</u>   |   | Address<br><u>300 S. Union Ave. Harde Chase, Md.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u><br>DUE TO <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerosis</u><br>DUE TO <u>Arteriosclerosis</u><br>(c) <u>Arteriosclerosis</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>Sym</u>                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>May 8, 1950</u> , to <u>March 21, 1961</u> , that I last saw the deceased alive on <u>March 20, 1961</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE<br><u>Dudley Phillips MD</u>   |   | ADDRESS (Street, city or town, state)<br><u>Harde Chase Md.</u>   |   |
| DATE SIGNED<br><u>3/23/61</u>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |   | 22b. DATE, THEREOF<br><u>3/24/61</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Not Elm</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Harde Chase Md</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Harde Chase Md.</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 27 '61</u>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Arthur P. Harris</u>   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

3157

03145

|  |   |  |   |
|--|---|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Harford</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Bel Air</u><br>c. LENGTH OF STAY IN 1b <u>Entire life</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.D. # 2</u>  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, res. date before admission)<br>a. STATE <u>md</u><br>b. COUNTY <u>Harford</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Bel Air</u><br>d. STREET ADDRESS <u>R.F.D. # 2</u> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>LAURA VIRGINIA GREER</u>   |   | <b>4. DATE OF DEATH</b><br><u>March 6 1961</u>   |   |
| <b>5. SEX</b><br><u>Female</u>   | <b>6. COLOR OR RACE</b><br><u>Col</u>                       | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><u>August 1878</u>     |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>House Work</u>  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Domestic</u> | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Harford Co. md</u>  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u> |
| <b>13. FATHER'S NAME</b><br><u>GEO. Washington Barrett</u>   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Annie Hall</u>   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | <b>16. SOCIAL SECURITY NO.</b><br><u>-</u>   |   |
| <b>17. INFORMANT</b><br><u>Eliz. E. Brown</u>  |   | <b>Address</b><br><u>612 S. Union Ave. Grace</u>   |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary artery disease</u><br>(c) <u>Ch. Cardio-Vascular Disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |  |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |   |  |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 5, 1961</u> , to <u>March 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1961</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.  |   |  |   |
| <b>22a. SIGNATURE</b><br><u>Willard P. Hudson</u> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>WILLARD P. HUDSON</u>  |   | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b><br><u>FOREST HILL, MD.</u>   |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |   | <b>23b. DATE THEREOF</b><br><u>3-9-61</u>  |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Asbury Cemetery</u>  |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Churchville, Harford Co. Md.</u>   |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Walter J. Bullock, Stave de Grace</u>  |   | <b>25a. REC'D BY REGISTRAR</b> <u>MAR 13 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kraus</u>  |   |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3158

03146

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>HARFORD</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u><br>c. LENGTH OF STAY IN 1b <u>4 DAYS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>HARFORD</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ABINGDON</u><br>d. STREET ADDRESS <u>Box 67</u> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Baby Boy</u><br>First <u>'A'</u> Middle Last <u>HARRIS</u>  |  | <b>4. DATE OF DEATH</b><br><u>MAR 25 1961</u><br>Month Day Year   |  |
| <b>5. SEX</b> <u>M</u><br><b>6. COLOR OR RACE</b> <u>C</u>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>MAR 21 1961</u><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>   |  | <b>9. AGE</b> (In years last birthday) <u>4</u><br>IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>HARFORD Co. MARYLAND</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>               |  |
| <b>13. FATHER'S NAME</b><br><u>Kenneth Eugene Norton</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>MILDRED R. HARRIS</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u><br><b>16. SOCIAL SECURITY NO.</b> <u>no</u>   |  | <b>17. INFORMANT</b><br><u>Hospital Records</u>   |  |

|   |  |  |
|---|--|--|
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity &amp; Atelectasis</u><br>(b) <u>1620</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>   |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |  |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>3/21</u> to <u>3/25</u> , 1961, that (I) (we) last saw the deceased alive on <u>3/25</u> 1961, and that death occurred at <u>AM</u> , from the causes and on the date stated above. |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>George T. Stansbury</u>   |  | <b>22b. DATE SIGNED</b><br><u>3/25/61</u>   |  | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>George T. Stansbury</u>  |  |
| <b>22d. ADDRESS</b><br><u>569 Revolution St. Havre de Grace, Md.</u>  |  | <b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input type="checkbox"/> <b>22g. STAFF PHYS.</b> <input type="checkbox"/> |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>3-25-61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Abingdon Methodist Cem.</u>  |  |
| <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Abingdon, Harford Co. Md.</u>   |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Elmer E. Bullard</u>  |  |  |  |
| <b>25a. REC'D BY REGISTRAR</b><br><u>MAR 30 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>C. L. H. H.</u>   |  |  |  |

2171213X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 3159 CERTIFICATE OF DEATH

|  |                                      |   |   |
|--|--------------------------------------|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>HARFORD</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u><br>c. LENGTH OF STAY IN It <u>20 hrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u> |                                      | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u><br>b. COUNTY <u>HARFORD</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u><br>d. STREET ADDRESS <u>Box 67</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Baby Boy "B" HARRIS</u>   |                                      | <b>4. DATE OF DEATH</b><br>Month <u>MARCH</u> Day <u>22</u> Year <u>1961</u>  |   |
| <b>5. SEX</b><br><u>Male</u>   | <b>6. COLOR OR RACE</b><br><u>CS</u> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><u>3/21/61</u> |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>none</u>  |                                      | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>none</u>   |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>MD (Harford Co.)</u>  |                                      | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |   |
| <b>13. FATHER'S NAME</b><br><u>Kenneth Eugene Norton</u>   |                                      | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Mildred HARRIS</u>  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>no</u>  |                                      | <b>16. SOCIAL SECURITY NO</b><br><u>no</u>  |   |
| <b>17. INFORMANT</b><br><u>Hospital Records</u>  |                                      | <b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity &amp; Congenital Atelectasis</u><br>DUE TO (b) <u>7:25</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>none</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e);<br><u>none</u> |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      | <b>20. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)<br><u>none</u>   |   |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b><br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |                                      | <b>20b. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>3</u>  |   |
| <b>20c. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |                                      | <b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>HAURE de GRACE</u>  |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 21, 1961</u> <b>to</b> <u>March 22, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>March 22, 1961</u> <b>and that death occurred at</b> <u>2:30 PM</u> <b>from the causes and on the date stated above.</b>           |                                      | <b>22a. SIGNATURE</b><br><u>George T. Stansbury</u>   |   |
| <b>22b. PHYSICIAN'S NAME</b> (Type)<br><u>George T. Stansbury</u>  |                                      | <b>22c. ADDRESS</b><br><u>569 Revolution St. Haure de Grace, Md.</u>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |                                      | <b>23b. DATE THEREOF</b><br><u>3-24-61</u>  |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Abingdon Methodist Cem</u>   |                                      | <b>23d. LOCATION</b> (City, town or county)<br><u>Abingdon, Harford Co. Md.</u>   |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Elmer E. Bullard</u>   |                                      | <b>25. REC'D BY REGISTRAR</b><br><u>MAR 30 '61</u>  |   |
| <b>25a. ADDRESS</b><br><u>Haure de Grace, Md.</u>  |                                      | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>William E. Evans</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

3160

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03148

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b><br>c. LENGTH OF STAY IN TB <b>2 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Army Hospital</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>3403 Crosshill Court</b> |  |
| 3. NAME OF DECEASED (Type or print) <b>Infant Girl</b><br>4. DATE OF DEATH <b>March 21 19 61</b>  |  | 5. SEX <b>Female</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b><br>12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>RICHARD PETER HEMPTON</b><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b><br>16. SOCIAL SECURITY NO. <b>N/A</b>  |  | 14. MOTHER'S MAIDEN NAME <b>EDNA LOUISE WAGNER</b><br>17. INFORMANT <b>Mrs Edna L Hempton (Mother)</b> Address <b>Baltimore, Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity, severe</b><br>DUE TO (b) <b>(Approx 6½ months gestation)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/><br>20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY Month, Day, Year <b>March 20 1961</b><br>Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED: 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                            |  |
| 21. I certify that (I) <b>Malcolm McLean</b> attended the deceased from <b>March 20 1961</b> to <b>March 21 1961</b> , that (I) <b>not</b> saw the deceased alive on <b>20 March 1961</b> , and that death occurred at <b>730A</b> , from the causes and on the date stated above.  |  | 22a. SIGNATURE <b>Malcolm McLean M.D.</b><br>22b. DATE SIGNED <b>March 21, 1961</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>MALCOLM MCLEAN Captain, MC</b><br>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b><br>23b. DATE THEREOF <b>3/22/1961</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b><br>23d. LOCATION (City, town or county) (State) <b>Aberdeen Proving Ground, Md.</b>  |  | 24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Fernald</b><br>25a. REC'D BY REGISTRAR <b>MAR 24 '61</b><br>25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>   |  |

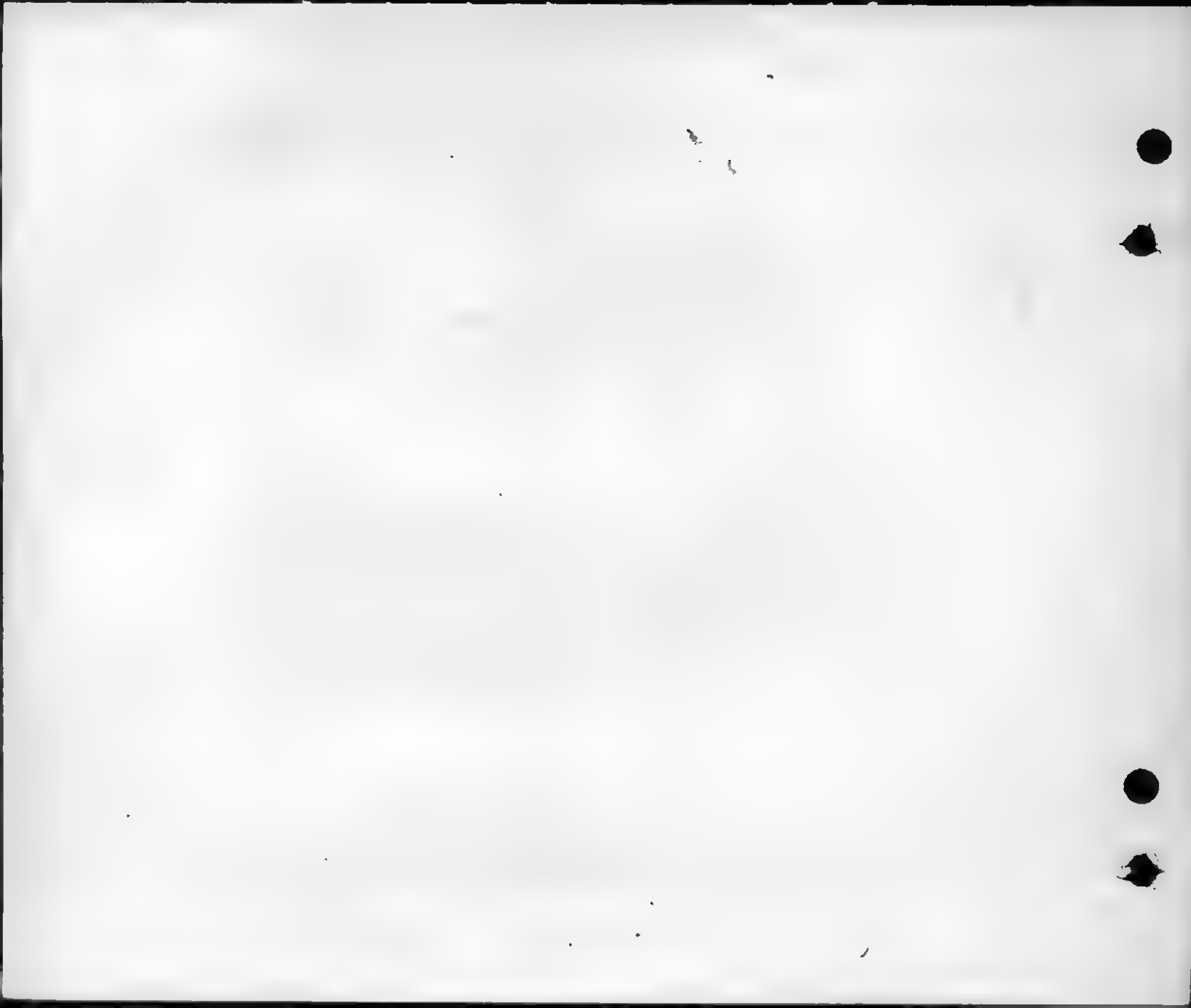


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

3161

03149

|   |   |   |  |   |   |  |  |
|---|---|---|--|---|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> MARYLAND   |   |   |  | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural ABERDEEN</b>   |   |   |  | c. LENGTH OF STAY IN 1b<br><b>20 YRS</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>ABERDEEN MD. R.D. 3</b>  |   |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>CHARLES EDWARD Holloway</b>  |   |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>MAR. 7 1961</b>  |   |  |  |
| 5 SEX<br><b>MALE</b>  | 6 COLOR OR RACE<br><b>WHITE</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 4, 1860</b>                         | 9. AGE (In years last birthday)<br><b>100</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.         | IF UNDER 24 HRS<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>HARFORD Co. MD.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>CHARLES A. Holloway</b>   |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET GALLUP</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>—</b>   |   | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  | 17. INFORMANT<br><b>Mrs. Trudwell Gilbert Aberdeen, Md. R.D. 3</b>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden pneumonia</b><br>441X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)     |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>Harford</b>                          | (County)<br><b>MD</b>   | (State)<br><b>MD</b>                              |  |  |
| 21 I certify that (I) (this hospital) attended the deceased from <b>Nov 3</b> 19 <b>61</b> to <b>MAR. 7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>March 7</b> 19 <b>61</b> , and that death occurred at <b>1:30</b> A. M. from the causes and on the date stated above |   |   |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Dudley Phillips MD</b>   |   | M.D.  | ATTENDING PHYS <input checked="" type="checkbox"/>             | MED DIRECTOR <input type="checkbox"/>   | STAFF PHYS <input type="checkbox"/>               | 22b. DATE SIGNED<br><b>3/10/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dudley Phillips MD</b>   |   | 22d. ADDRESS<br><b>Darlington, Md</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>Mar 11, 1961</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT ZION CEM.</b>   | 23d. LOCATION (City, town, or county)<br><b>HARFORD Co. MD</b> | (State)<br><b>MD</b>  |   |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>N. Madison Mitchell</b>  |   |   | ADDRESS<br><b>Harford Grace</b>                                |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 14 '61</b> | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thoms</b>   |  |



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The attending physician or the funeral director must be present at the time of death. The law requires that the death certificate be executed within 24 hours after death. The attending physician or the funeral director must be present at the time of death.

M I

1

1. PLACE OF DEATH  
a. COUNTY  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE  
b. COUNTY  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print)  
First Middle Last

4. DATE OF DEATH  
Month Day Year

5. SEX  
6. COLOR OR RACE  
7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH  
Month Day Year

9. AGE (In years last birthday)  
If UNDER 1 YEAR: Months Days  
If UNDER 24 HRS.: Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (County & State, or foreign country)  
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) DUE TO  
Conditions, if any, which gave rise to immediate cause (b) DUE TO  
(c), stating the underlying cause last.  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year  
Hour e.m. p.m.  
20d. INJURY OCCURRED While at work Not While at work  
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)  
20f. (City or town) (County) (State)

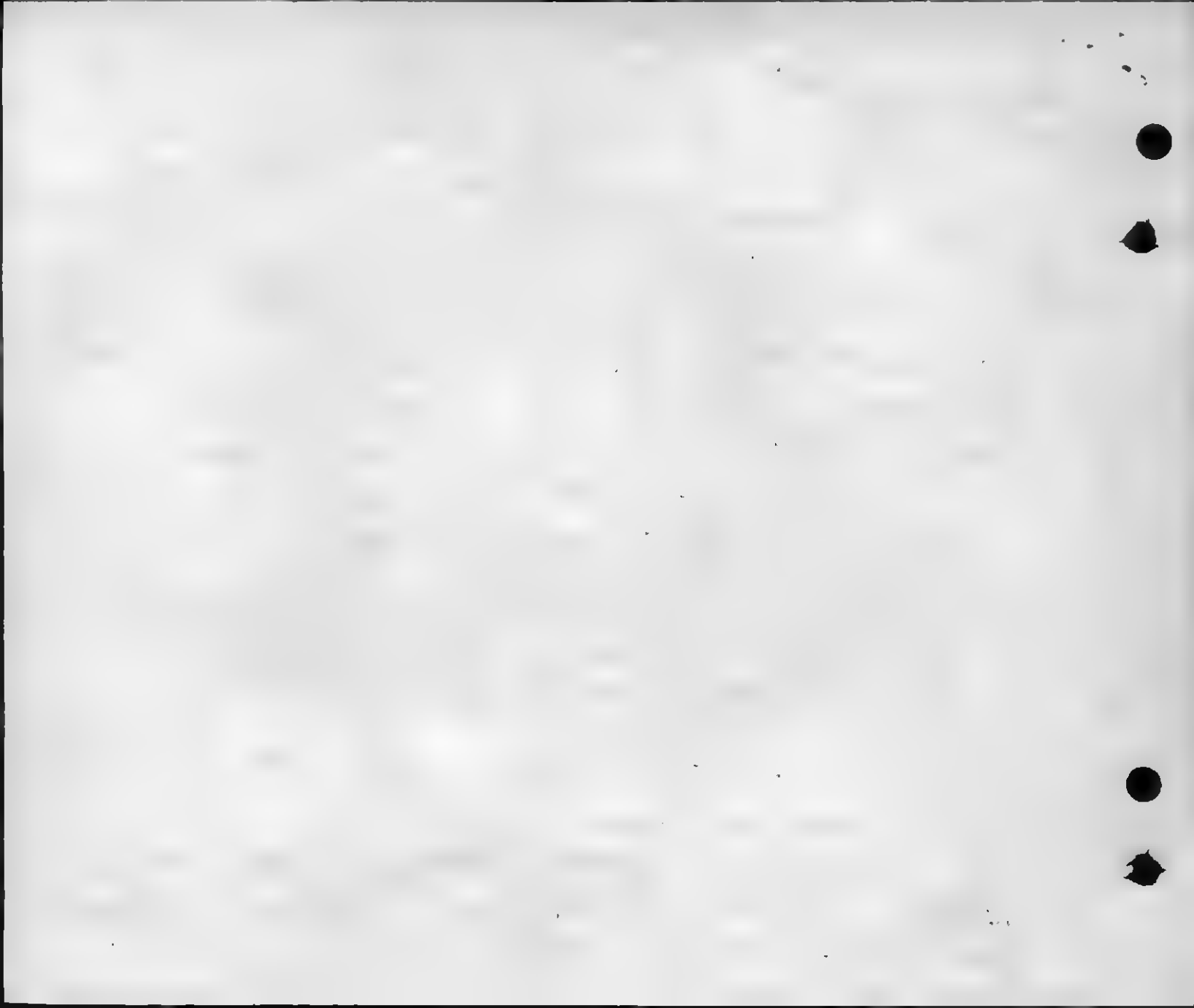
21. I certify that (I) (this hospital) attended the deceased from ..... 1957 to March 5, 1961, that (I) (we) last saw the deceased alive on March 5, 1961, and that death occurred at 3:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE  
22b. DATE SIGNED  
22c. PHYSICIAN'S NAME (Type)  
22d. ADDRESS

23a. BURIAL - CREMATION, (Specify)  
23b. DATE THEREOF  
23c. NAME OF CEMETERY OR CREMATORY  
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
25a. REC'D BY REGISTRAR DATE  
25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3163

## CERTIFICATE OF DEATH

03151

**1. PLACE OF DEATH**

a. COUNTY

*HARFORD*

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

*HAVER DE GRACE*

c. LENGTH OF STAY IN 1b

*19 hrs*

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

*HARFORD MEMORIAL HOSPITAL*

**2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)**

a. STATE

*MD*

b. COUNTY

*HARFORD*

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

*525 Fountain St*

d. STREET ADDRESS

*HAVER DE GRACE*

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

*DONALD B. INMAN*

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

*March 11 1961*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

*2/10/1879*

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Retired*

10b. KIND OF BUSINESS OR INDUSTRY

*Shoe*

11. BIRTHPLACE (County & State, or foreign country)

*N. Carolina*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*James R. Inman*

14. MOTHER'S MAIDEN NAME

*Miranda Means*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

*U.S. Army*

16. SOCIAL SECURITY NO.

*Unknown*

17. INFORMANT

*Mr. India P. Inman*

Address

*525 Fountain St. Harford, Md.*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

*RUPTURED ANEURYSM ABDOMINAL AORTA*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

*ARTERIOSCLEROSIS*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from *3-10*, 1961, to *3-11*, 1961, that (I) ~~(we)~~ last saw the deceased alive on *MARCH 11*, 1961, and that death occurred at *4:10 AM*, from the causes and on the date stated above.

22a. SIGNATURE

*D. Hirsch*

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

3-11-1961

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

*GUNTHER D. HIRSCH*

22d. ADDRESS

*HAVER DE GRACE, MARYLAND*

23a. BURIAL, CREMATION, REMOVAL (Specify)

*3/14/61*

23c. NAME OF CEMETERY OR CREMATORY

*Angel Hill*

23d. LOCATION (City, town or county)

*Harford County, Md.*

24. FUNERAL DIRECTOR'S SIGNATURE

*Funeral Home, Harford County, Md.*

25a. REC'D BY REGISTRAR

DATE *MAR 16 '61*

25b. REGISTRAR'S SIGNATURE

*Arthur L. Kraus*

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or funeral director for 4 months after the death. The law also requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The 4 months retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

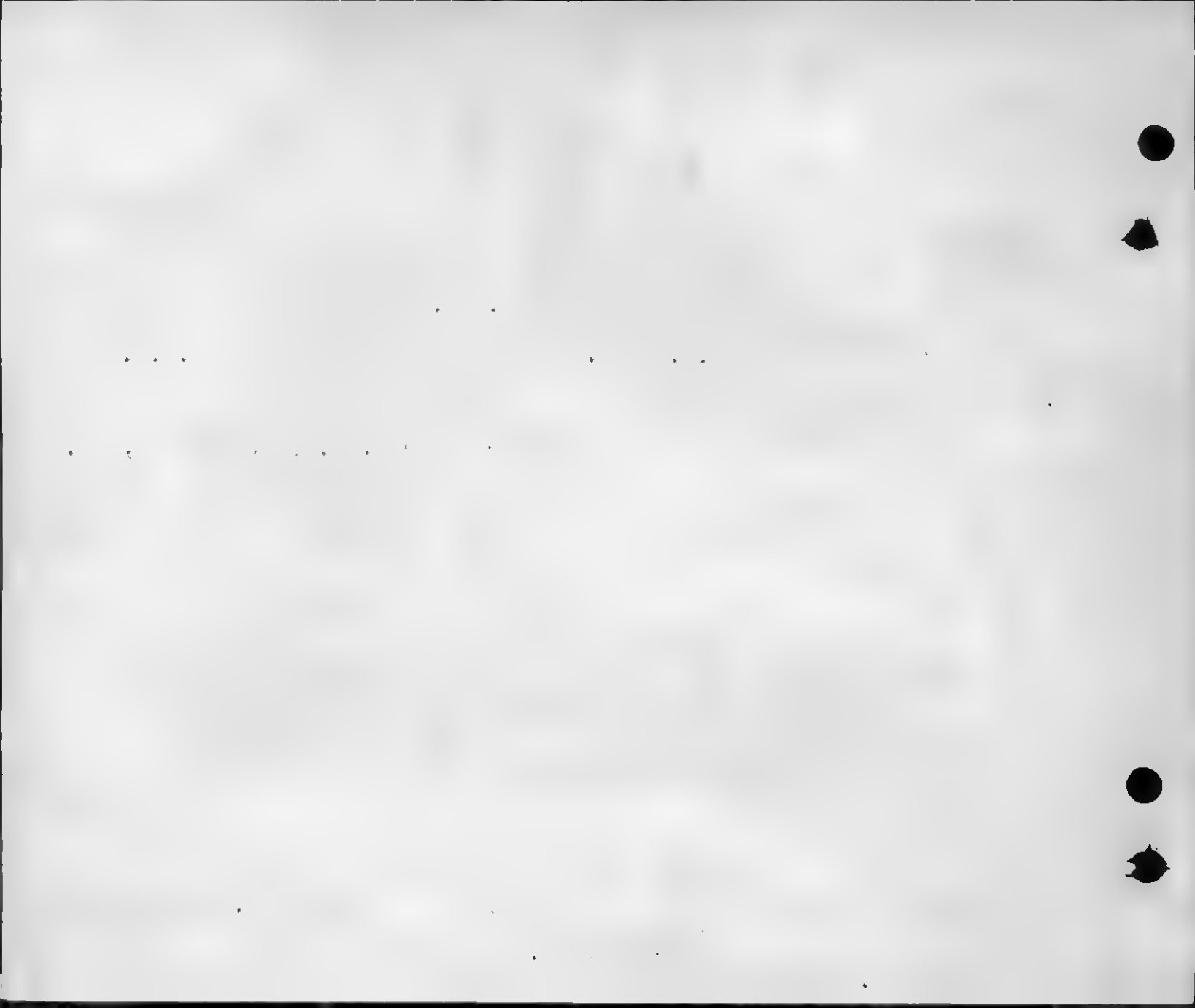
3164

3164

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03152

|   |                           |   |  |
|---|---------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u><br>c. LENGTH OF STAY IN TB <u>3 hrs 50 min</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>  |                           | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>HARFORD</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u><br>d. STREET ADDRESS <u>R.D. 2 Box 158</u> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>CYRIL</u><br>First Middle Last  |                           | 4. DATE OF DEATH<br><u>MAR 10 1961</u><br>Month Day Year  |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>Nov. 22, 1893</u><br>Month Day Year |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Photographer (Ret)</u>  |                           | 11. BIRTHPLACE (County & State, or foreign country)<br><u>CZECHOSLOVAKIA</u>  |  |
| 13. FATHER'S NAME<br><u>IGNATZ KOTRAS</u>   |                           | 14. MOTHER'S MAIDEN NAME<br><u>MAXI MILLIANA</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>  |                           | 17. INFORMANT<br><u>Edward Kotras, R.D. 2, Bel Air, Md.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per use for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO (b) <u>Coronary Thrombosis</u><br>DUE TO (c) <u>Coronary Atherosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMAL DISEASE CONDITION GIVEN IN PART I (e) <u>none</u> |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1950</u> to <u>March 1961</u> that (I) (we) last saw the deceased alive on <u>March 10 1961</u> and that death occurred at <u>2:50 PM</u> from the causes and on the date stated above.   |                           |   |  |
| 22a. SIGNATURE<br><u>Ralph Harty</u><br>M.D.  |                           | 22b. DATE SIGNED<br><u>3/10/61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>L. Ralph Harty</u>   |                           | 22d. ADDRESS<br><u>Churchville Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                           | 23b. DATE THEREOF<br><u>3/13/61</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>St Francis Cemetery</u>  |                           | 23d. LOCATION (City, town or county) (State)<br><u>Abingdon, Maryland</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>John G. Tarring</u>  |                           | 25a. REC'D BY REGISTRAR<br><u>MAR 13 '61</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles S. Evans</u>   |                           | 25c. REGISTRAR'S NAME<br><u>Charles S. Evans</u>  |  |



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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3165 03153

1. PLACE OF DEATH  
a. COUNTY Harford MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre de Grace  
c. LENGTH OF STAY in 1b 1 hour  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Md b. COUNTY Harford  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Edgewood  
d. STREET ADDRESS 1

3. NAME OF DECEASED (Type or print) Raymond Woodrow Kregar  
First Middle Last  
4. DATE 3-4 19 61  
DEATH Month Day Year

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Dec. 25, 1913  
9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Expeditor 10b. KIND OF BUSINESS OR INDUSTRY Missle 11. BIRTHPLACE (County & State, or foreign country) Virginia  
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Kregar 14. MOTHER'S MAIDEN NAME Rusetta Jones  
Address Kregar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO 217-05-2010 17. INFORMANT Gladys L. Kregar  
Address Edgewood R.D., Md.,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Acute CORONARY OCCLUSION  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 hours  
DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

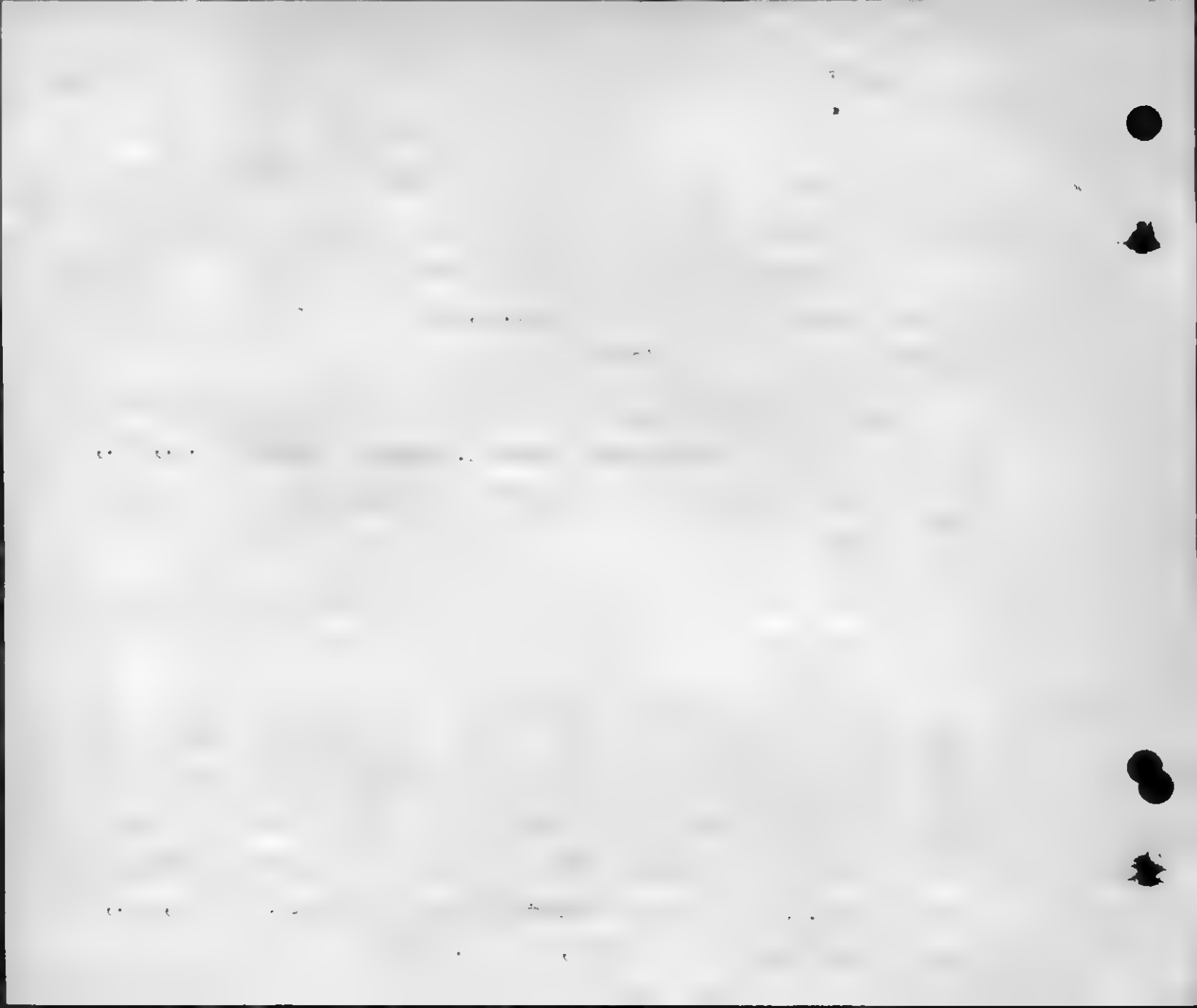
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
Hour a.m. p.m. 19 While at work ☐ Not While at work ☐

21. I certify that (I) (this hospital) attended the deceased from ... 19... to ... 19..., that (I) (we) last saw the deceased alive on ... 19... and that death occurred at 2:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE Gunther D. Hirsch M.D. 22b. DATE SIGNED 3-4-61  
22c. PHYSICIAN'S NAME (Type) GUNTHER D. HIRSCH 22d. ADDRESS 421 CONGRESS AV. HARRE DE GRACE

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Mar. 7, 1961 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens 23d. LOCATION (City, town or county) (State) Bel Air, Harford, Md.,

24. FUNERAL DIRECTOR'S SIGNATURE Howard R. McCombs Jr. ADDRESS Abingdon, Maryland. 25a. REC'D BY REGISTRAR 7 25b. REGISTRAR'S SIGNATURE 06  
DATE



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3166

03154

|  |                                     |   |   |
|--|-------------------------------------|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>HARFORD</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u><br>c. LENGTH OF STAY IN 1b <u>10 DAYS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>   |                                     | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>HARFORD</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN Rural #1</u><br>d. STREET ADDRESS <u>Box 175</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>MATILDA ANN LONG</u>  |                                     | <b>4. DATE OF DEATH</b><br>Month <u>MARCH</u> Day <u>13</u> Year <u>1961</u>  |   |
| <b>5. SEX</b><br><u>F</u>  | <b>6. COLOR OR RACE</b><br><u>W</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><u>June 6th / 1898</u> |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                                     | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>  |   |
| <b>13. FATHER'S NAME</b><br><u>CHARLES SPIES</u>   |                                     | <b>14. MOTHER'S MAIDEN NAME</b><br><u>BARBARA NOVANTY</u>   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>   |                                     | <b>16. SOCIAL SECURITY NO.</b> <u>214-12-0207</u>   |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><u>150 D</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>Generalized circulatory failure<br>Thrombosis of mesenteric artery<br>Generalized arteriosclerosis<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes mellitus</u> |                                     | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>8 hr.</u><br><u>10 days</u><br><u>10 yr.</u>  |   |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |                                     | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)  |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>19</u> a.m. p.m.  |                                     | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |                                     | <b>20f. (City or town)</b> (County) (State)   |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from...</b> <u>1947</u> , to <u>3-13-61</u> , that (I) (we) last saw the deceased alive on <u>3-13-61</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.  |                                     |   |   |
| <b>22a. SIGNATURE</b><br><u>Peter P. Rodman</u>  |                                     | <b>22b. DATE SIGNED</b><br><u>3-13-61</u>   |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Peter P. Rodman, M.D.</u>  |                                     | <b>22d. ADDRESS</b><br><u>8 Law St., Aberdeen, Md.</u>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |                                     | <b>23b. DATE THEREOF</b><br><u>3/17/61</u>  |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>St. Francis Cemetery</u>   |                                     | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Aberdeen, Maryland</u>  |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>John &amp; Barry - Aberdeen Maryland</u>   |                                     | <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>MAR 20 '61</u>  |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kenna</u>  |                                     |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT.  
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TO D. HEALTH DEPT. EXAMINER: This certificate should be executed within 72 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**3167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03155

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Harford</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chesapeake Road</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u><br>b. COUNTY <u>Harford</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u><br>d. STREET ADDRESS <u>Chesapeake Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Arthur Leon Lufkin</u><br>5. SEX <u>M</u><br>6. COLOR OR RACE <u>W</u><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | <b>4. DATE OF DEATH</b> <u>March 8</u> 19 <u>61</u><br>8. DATE OF BIRTH <u>12-25-1897</u><br>9. AGE (in years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Cutter</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Factory</u><br>11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | <b>13. FATHER'S NAME</b> <u>Frank Lufkin</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Eva Reed</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>Navy WW-1</u><br><b>16. SOCIAL SECURITY NO.</b> <u>003-01-4526</u><br><b>17. INFORMANT</b> <u>James A. Lufkin</u> Address <u>Chesapeake Rd. Aberdeen, Md.</u>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>25W L. Chest</u><br><u>776X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(a), stating the underlying cause last. } DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) _____<br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self with 12 Ga. Shot Gun</u>  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <u>3-8-61</u><br>Hour <u>10</u> a.m. <u>pm</u>   |  | <b>20d. INJURY OCCURRED</b> <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>  |  | <b>20f. (City or town)</b> <u>Aberdeen</u> <b>(County)</b> <u>Harford</u> <b>(State)</b> <u>MD</u>   |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u><br><b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer, MD</u>   |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <u>Bel Air, MD</u><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <u>3-8-61</u>   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>  |  | <b>22b. DATE THEREOF</b> <u>2/9/1961</u>   |  |
| <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Acworth Cemetery</u>  |  | <b>22d. LOCATION (City, town, or country)</b> <u>Acworth New Hampshire</u> <b>(State)</b> _____  |  |
| <b>23. FUNERAL DIRECTOR</b> <u>John G. Garring - Aberdeen, Md.</u>   |  | <b>24a. REC'D BY REGISTRAR</b> <u>MAR 13 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>  |  |



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|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b>   |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived - If institution - Residence before admission)<br>a. STATE <b>Maryland</b> |  | b. COUNTY <b>Harford</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>15 Yrs</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>                 |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Hospital Aberdeen Proving Ground, Md</b>   |                                  |   |  | d. STREET ADDRESS<br><b>6 West Market</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br><b>JOHN ANDREWS MACLAUGHLIN</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>18</b> Year <b>1961</b>   |  |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 20, 1890</b>   |  | 9. AGE (In years last birthday)<br><b>70 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Soldier-Colonel (Ret)</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>US Army Retired</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John Thomson MacLaughlin</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Dyer</b>   |  |   |   |
| 15. WAS DECEASED EVER IN JAIL OR HOSPITAL?<br>(Yes no or unknown) <b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>215-32-9639</b>  |  | 17. INFORMANT<br><b>Charles Andrews MacLaughlin (Son) Same as 2)</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>43X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic cerebral vascular disease</b><br>DUE TO<br>(c) <b>Hypertensive cardiovascular disease</b> |                                  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>13 days</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) <b>physician</b> attended the deceased from <b>February 2, 1960, to 18 March, 1961</b> , that (I) <b>yes</b> lost the deceased alive on <b>March 17, 1961</b> , and that death occurred at <b>4:15 A.M.</b> , from the causes and on the date stated above.  |                                  |   |  |   |  |   |   |
| 22a. SIGNATURE<br><b>J. A. Grossman</b>   |                                  |   |  | 22b. DATE<br><b>March 18, 1961</b>  |  |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>J. A. GROSSMAN Capt MC</b>   |                                  |   |  | 22d. ADDRESS<br><b>US Army Hospital<br/>Aberdeen Proving Ground, Maryland</b>                                       |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Mar. 20, 1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Post Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Army Chemical Center, Md.</b>                 |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard K. Thompson</b>   |                                  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 21 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thomas</b>   |   |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3169

## CERTIFICATE OF DEATH

Reg. Dist. 13157

|   |                               |   |                                      |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Harford</i><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen #2</i><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Gilbert Road</i>   |                               | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen Rural #2</i><br>d. STREET ADDRESS <i>Belter-Aberdeen Road</i><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Thelma</i> Middle <i>Hughes</i> Last <i>McLore</i>  |                               | 4. DATE OF DEATH<br>Month <i>3</i> Day <i>21</i> Year <i>1961</i>   |                                      |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <i>June 29-1901</i> |
| 9. AGE (In years last birthday) <i>19</i> yrs   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |                                      |
| 13. FATHER'S NAME <i>Carroll T. Hughes</i>  |                               | 14. MOTHER'S MAIDEN NAME <i>Archie U. Greenland</i>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <i>213-38-6120</i>  |                                      |
| 17. INFORMANT <i>Mrs Willard Pyle = Aberdeen Rural #2 ind.</i>  |                               | Address   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br>DUE TO <i>Coronary occlusion</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary arteriosclerosis</i><br>DUE TO (c) <i>4 yr.</i> |                               |   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arterial hypertension; Cerebral arteriosclerosis</i>   |                               |   |                                      |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |   |                                      |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                               | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>  |                                      |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      |
| 20f. (City or town)   |                               | (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <i>12-28-1960</i> , to <i>3-21-1961</i> , that I last saw the deceased alive on <i>12-28-1960</i> , and that death occurred at <i>1:20 PM</i> , from the causes and on the date stated above.   |                               |   |                                      |
| ACTUAL SIGNATURE <i>Peter P. Rodman</i>   |                               | ADDRESS (Street, city or town, state) <i>8 Low St - Aberdeen, Md.</i>   |                                      |
| DATE SIGNED <i>3-23-61</i>  |                               |   |                                      |
| PHYSICIAN'S NAME (Type) <i>Peter P. Rodman M.D.</i>   |                               |   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                               | 22b. DATE THEREOF <i>3/24/1961</i>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Swick Chapel Cemetery</i>   |                               | 22d. LOCATION (City, town, or county) (State) <i>Aberdeen Rural #2 ind.</i>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Parving - Aberdeen, Md.</i>   |                               | ADDRESS   |                                      |
| 24a. REC'D BY REGISTRAR <i>MAR 27 1961</i>  |                               | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Hanna</i>  |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

80

91

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

3171

04345

|   |                                 |   |   |
|---|---------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURDE GRACE</u><br>c. LENGTH OF STAY IN IL <u>20 hr</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL</u> |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u><br>b. COUNTY <u>HARFORD</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURDE GRACE</u><br>d. STREET ADDRESS <u>1816 Locust</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br><u>MALLORY</u>   |                                 | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>25</u> Year <u>1961</u>   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>March 24, 1961</u> |
| 9. AGE (In years) IF UNDER 1 YEAR<br>last birthday Yrs. <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>   |                                 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>   |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |   |
| 13. FATHER'S NAME   |                                 | 14. MOTHER'S MAIDEN NAME <u>GOLDIE ARCINA MALLORY</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                                 | 16. SOCIAL SECURITY NO. (If yes give number or date of service)   |   |
| 17. INFORMANT<br><u>Mother - 816 Locust St, HAURDE GRACE</u>  |                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u><br>DUE TO (b) <u>Breath Delivery</u><br>DUE TO (c) <u>Breath Delivery</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 | 20. INTERVAL BETWEEN ONSET AND DEATH  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 24, 1961</u> to <u>March 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 25, 1961</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.                        |                                 | 22. SIGNATURE <u>[Signature]</u>  |   |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   |                                 | 24. DATE TIME OF REMOVAL <u>3/25/61</u>   |   |
| 25. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>  |                                 | 26. LOCATION (City, town or county) (State) <u>HAURDE GRACE, MD</u>   |   |
| 27. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>   |                                 | 28. ADDRESS <u>ADMINISTRATOR</u>  |   |
| 29. REC'D BY REGISTRAR <u>[Signature]</u>   |                                 | 30. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |   |
| DATE <u>MAY 5 '61</u>   |                                 | DATE <u>MAY 5 '61</u>   |   |

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3172

## CERTIFICATE OF DEATH

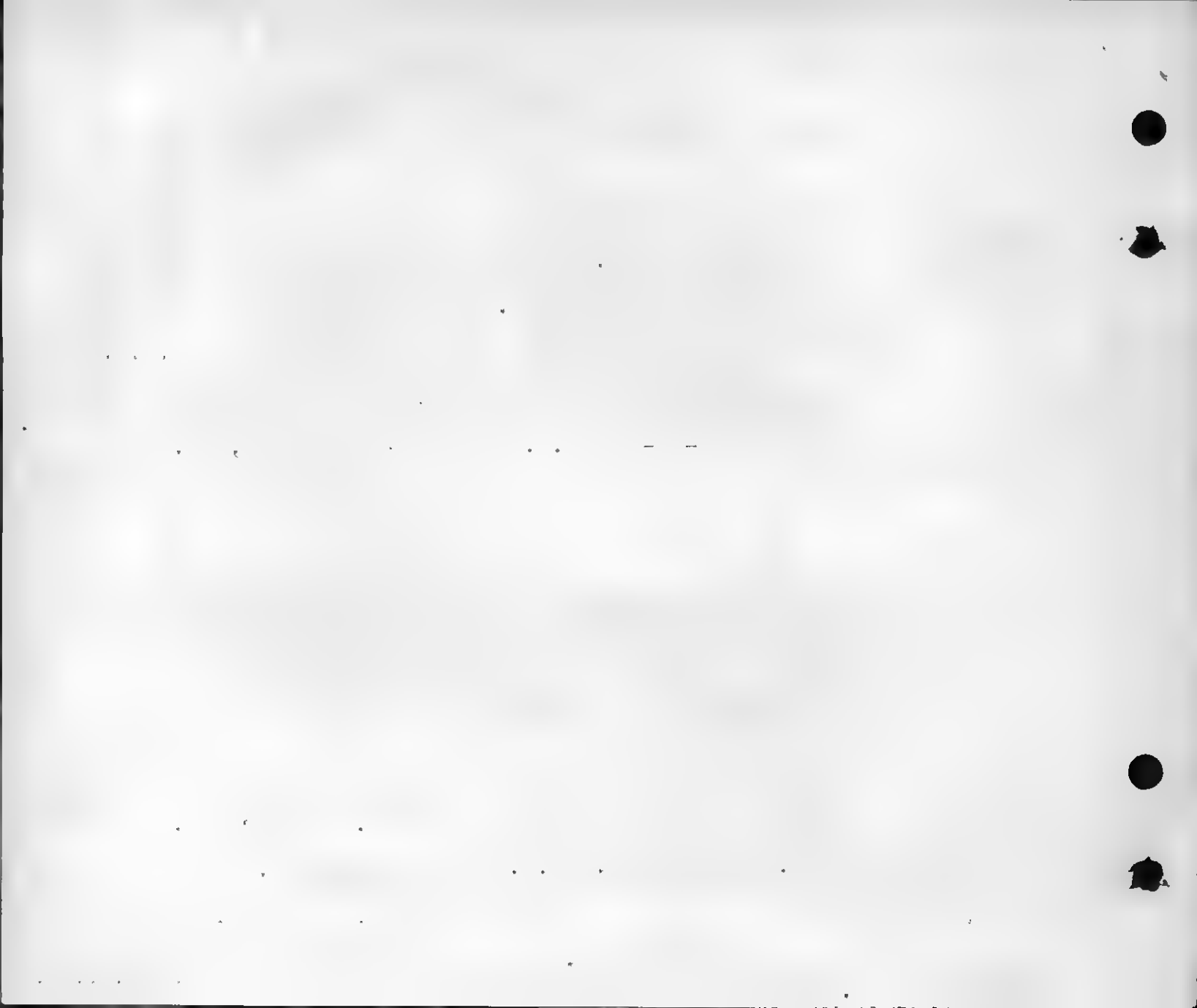
03159

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Harford</b> <b>MARYLAND</b>   |  |  |  | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>                   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aberdeen</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>116 Rigdon Road</b>   |  |  |  | e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>HENRIETTA</b> Middle <b>W.</b> Last <b>McFADDEN</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>8</b> Year <b>19 61</b>  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6 COLOR OR RACE<br><b>White</b>          |  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 16, 1918</b>                               |  |
| 9 AGE (In years last birthday)<br><b>43</b> yrs  |  | IF UNDER 1 YEAR<br>Months Days Hours Min |  | IF UNDER 24 HRS<br>Months Days Hours Min   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bank Teller</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>           |  |
| 12 CITIZEN OF WHAT COUNTRY.<br><b>U.S.A.</b>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>William Harry Webster</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Frances Snodgrass</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>217-24-9251</b>  |  |  |  |
| 17. INFORMANT<br><b>E.L. McFadden, Aberdeen, Md.</b>   |  |  |  | Address <b>116 Rigdon Rd.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Inanition</b><br>DUE TO (b) <b>Metastatic Carcinoma of breast</b><br>DUE TO (c) <b>1 year</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>11-22-60</b> to <b>3-8</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>3-8-61</b> , 19 <b>61</b> , and that death occurred at <b>5:45 PM</b> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>617 W. Bel Air Ave.</b> DATE SIGNED <b>3/10/61</b><br>ACTUAL SIGNATURE <b>Barry J. Plunkett Jr.</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Barry J. Plunkett Jr. M.D. Aberdeen, Md.</b> |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>3/11/61</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial Gardens, Bel Air, Maryland</b>   |  | 22d. LOCATION (City, town, or county) (State)                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John G. Tarring</b><br><b>Aberdeen, Md.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 13 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Evans</b>                  |  |

John G. Tarring

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

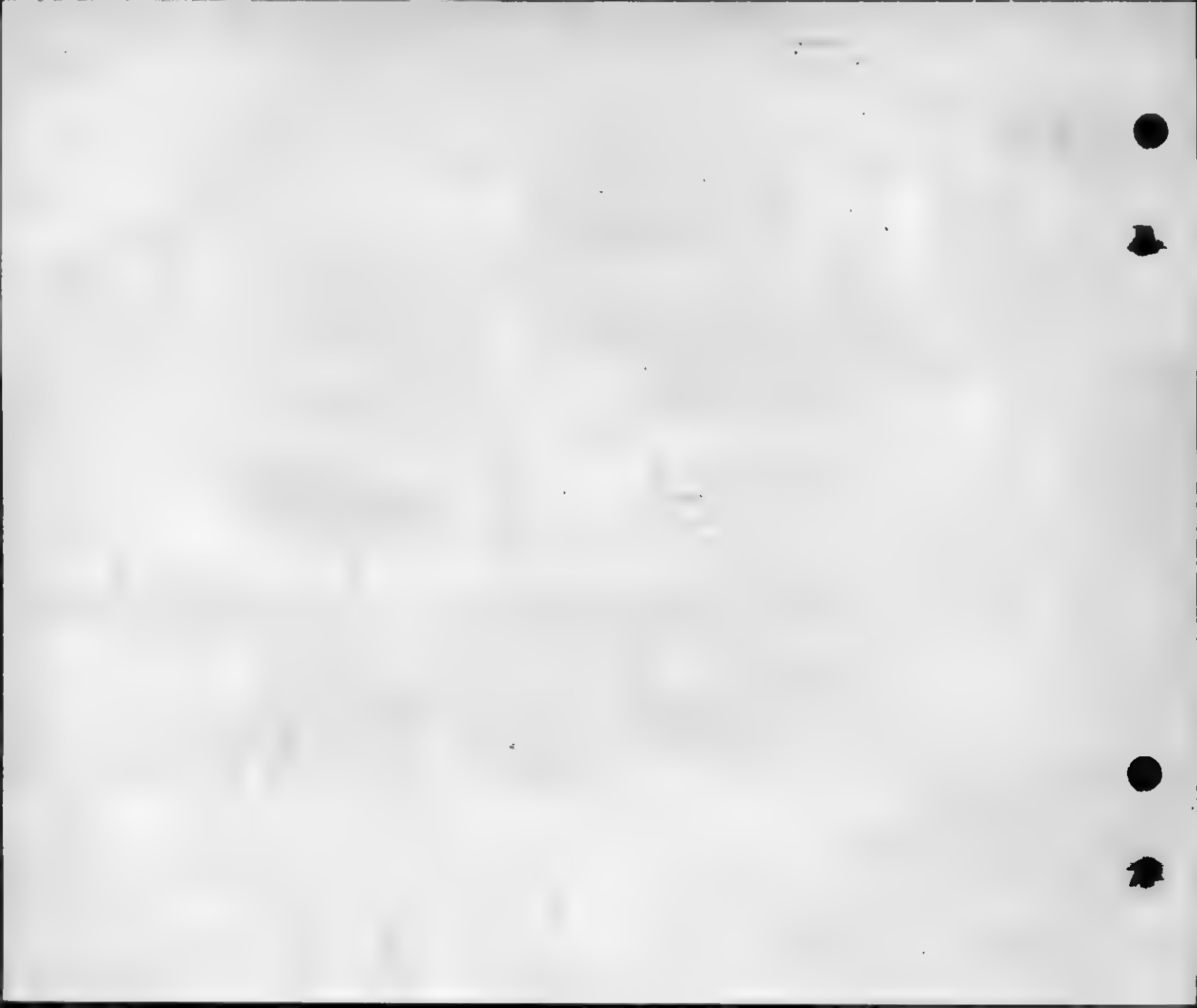
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03160

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Hartford</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u><br>c. LENGTH OF STAY in 1b <u>13 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions; residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Hartford</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u><br>d. STREET ADDRESS <u>314 Lafayette</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Shirley Wilkard McFarland</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>3</u> Day <u>5</u> Year <u>1961</u>  |  | <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>  |  |  |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b> <u>Oct. 16 1912</u><br><b>9. AGE</b> (In years last birthday) <u>48</u> yrs.   |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Premix MAN</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Coca Cola Co.</u>  |  |  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Va.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  | <b>13. FATHER'S NAME</b> <u>Edward McFarland</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Minnie Riley</u>  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>215-14-1827</u><br><b>17. INFORMANT</b> <u>Georgia McFarland</u> Address <u>Harre-de-Grace, MD.</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u><br>DUE TO (b) <u>Carcinoma lung</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>1 yr</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>1 yr</u> |  |  |  |   |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>19</u> a.m. p.m.  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <b>20f. (City or town)</b> (County) (State)  |  | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/1/1961</u> <b>to</b> <u>3/5/1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3/5/1961</u> <b>and that death occurred at</b> <u>5:35 PM</u> <b>from the causes and on the date stated above.</b> |  |   |  |  |  |
| <b>22a. SIGNATURE</b> <u>Irvin L. Wachsman</u> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>IRVIN L. WACHSMAN</u>  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b> <u>407 S. UNION AVE HARRE-DE-GRAVE, MD.</u>  |  | <b>22b. DATE SIGNED</b> <u>3/5/61</u>   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>   |  | <b>23b. DATE THEREOF</b> <u>MAR 8, 1961</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>BEL AIR MEMORIAL GARDEN</u>  |  |  |  |
| <b>23d. LOCATION</b> (City, town or county) (State) <u>HARTFORD MD</u>   |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert S. Knecht</u> ADDRESS <u>Harre-de-Grace, MD</u>  |  |   |  |  |  |
| <b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 7 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>Robert S. Knecht</u>  |  |   |  |  |  |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

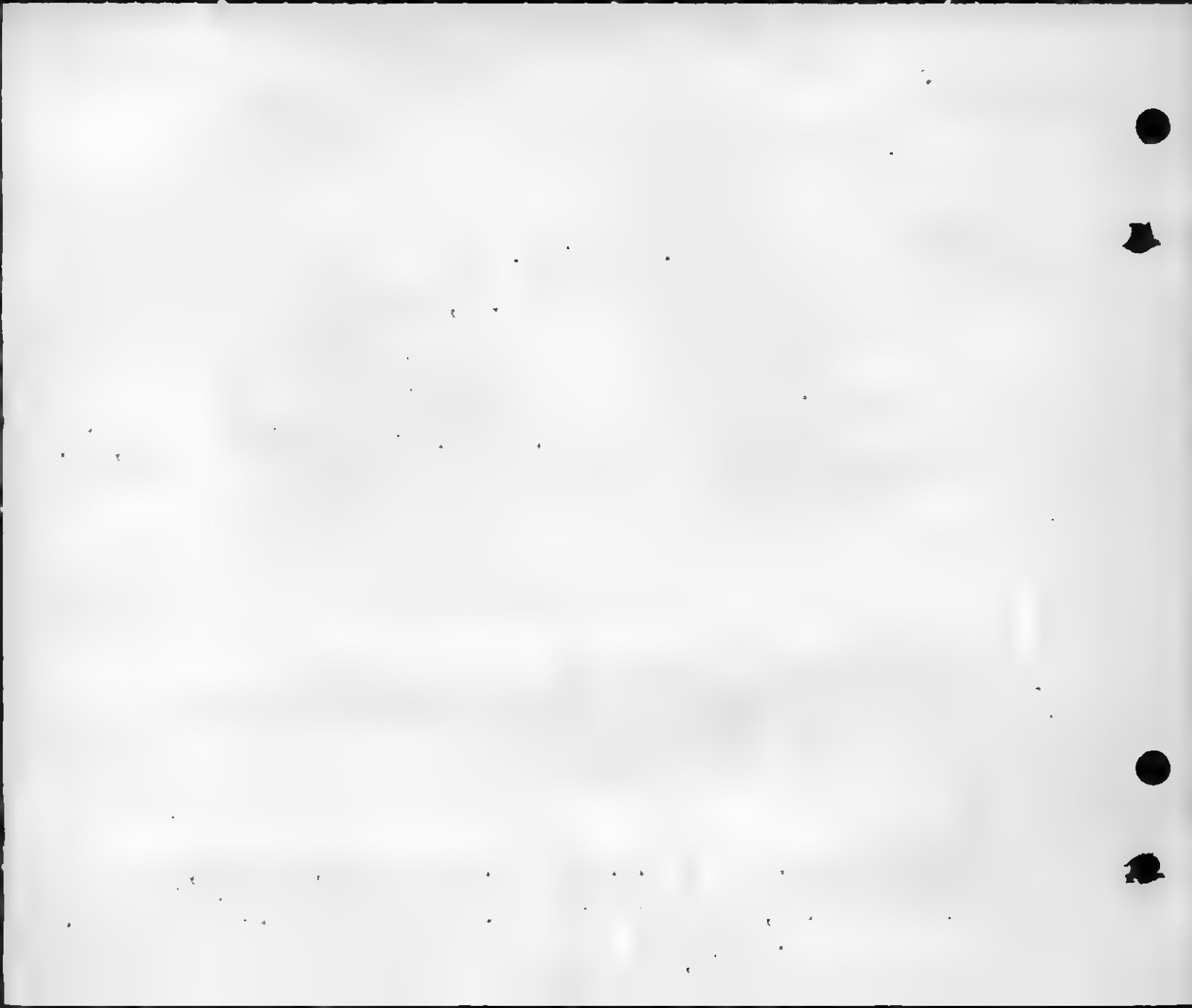
VS A15 (4)  
15M 10/57

Richard Lininger Funeral Home  
Curwensville, Pennsylvania

3174 Item 4 Form G-64 4/4/61 jwk  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 03161

|   |                              |   |  |  |   |  |  |
|---|------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air (Rural)</b>  |                              |   |  | c. LENGTH OF STAY IN 1b<br><b>2 months</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Harford Convalescent Home</b>  |                              |   |  | d. STREET ADDRESS<br><b>620 Fountain Street</b>  |   |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |   |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Vada</b> Middle <b>B.</b> Last <b>Miller</b>  |                              |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>27</b> Year <b>1961</b>  |   |  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 23, 1883</b> | 9. AGE (In years last birthday)<br><b>77 yrs.</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS<br>Months Days Hours Min.                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Ansonville Pa</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                  |  |
| 13. FATHER'S NAME<br><b>George W. Bollinger</b>   |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mollorie Mays</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                              | 16. SOCIAL SECURITY NO.<br><b>190-03-6880</b>   |  | 17. INFORMANT (Son)<br><b>Mr. Fred E. Miller</b> <b>620 Fountain St. Havre de Grace, Md.</b>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic CV disease</b><br><b>4221</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ |                              |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                              |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that I attended the deceased from <b>3-14</b> , 19 <b>61</b> , to <b>3-27</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>3-25</b> , 19 <b>61</b> , and that death occurred at <b>4:30</b> P. M. from the causes and on the date stated above.  |                              |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Gerald C Palmer</b> M.D.  |                              |   |  | ADDRESS (Street, city or town, state) <b>Bel Air, Md.</b> DATE SIGNED <b>3-28-61</b>   |   |  |  |
| PHYSICIAN'S NAME (Type) <b>Gerald C. Palmer M.D.</b>  |                              |   |  | S. Main Street, Bel Air, Maryland  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 22b. DATE THEREOF<br><b>Mar. 30, 1961</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fruit Hill Cem.</b>   |   | 22d. LOCATION (City or town, county, state)<br><b>Pennsylvania</b> (State) |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph W. Foster</b>   |                              | ADDRESS<br><b>W. Broadway &amp; Williams Bel Air, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br><b>MAR 30 '61</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. L. Foster</b>                          |  |



FOR STATE  
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed with 24 hours after death. Delay is necessary. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03162

|   |                           |  |                                  |
|---|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u>   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Harford</u>   |                                  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>   |                           | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>  |                                  |
| c. LENGTH OF STAY in 1b <u>40 hrs.</u>  |                           | d. STREET ADDRESS <u>Robin Hood Road</u>   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |
| 3. NAME OF <u>Stella Marie Moor</u><br>(Type or print)  |                           | 4. DATE OF DEATH <u>March 26</u> 19 <u>61</u>  |                                  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>2/3/1936</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club</u>   |                           | 11. BIRTHPLACE (State or foreign country) <u>N. C.</u>   |                                  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Metals</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |                                  |
| 13. FATHER'S NAME <u>Lee Stanley</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Anna H. Hughes</u>   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                           | 16. SOCIAL SECURITY NO <u>Unknown</u>  |                                  |
| 17. INFORMANT <u>Carl Moore</u>   |                           | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fracture skull</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) _____ |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Yes</u>  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>   |                                  |
| 20c. TIME OF INJURY Month, Day, Year <u>3-4 1961</u>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> <u>At work</u>  |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Robin Hood Road</u>   |                           | 20f. (City or town) <u>Harford</u> (County) <u>Md.</u> (State) <u>Md.</u>  |                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |                                  |
| ACTUAL SIGNATURE <u>Gerald E Palmer</u>   |                           | CHIEF MEDICAL EXAMINER <u>3-26-61</u>  |                                  |
| EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>   |                           | DEPUTY MEDICAL EXAMINER <u>Bel Air, Md.</u>  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/29/61</u>  |                           | 22b. DATE THEREOF <u>Bel Air Memorial</u>  |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Md</u>  |                           | 22d. LOCATION (city, town, or country) (State) <u>Md</u>   |                                  |
| 23. FUNERAL DIRECTOR <u>Harold Shaw</u>   |                           | 24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>   |                                  |
| ADDRESS <u>Bel Air, Md.</u>   |                           | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |                                  |

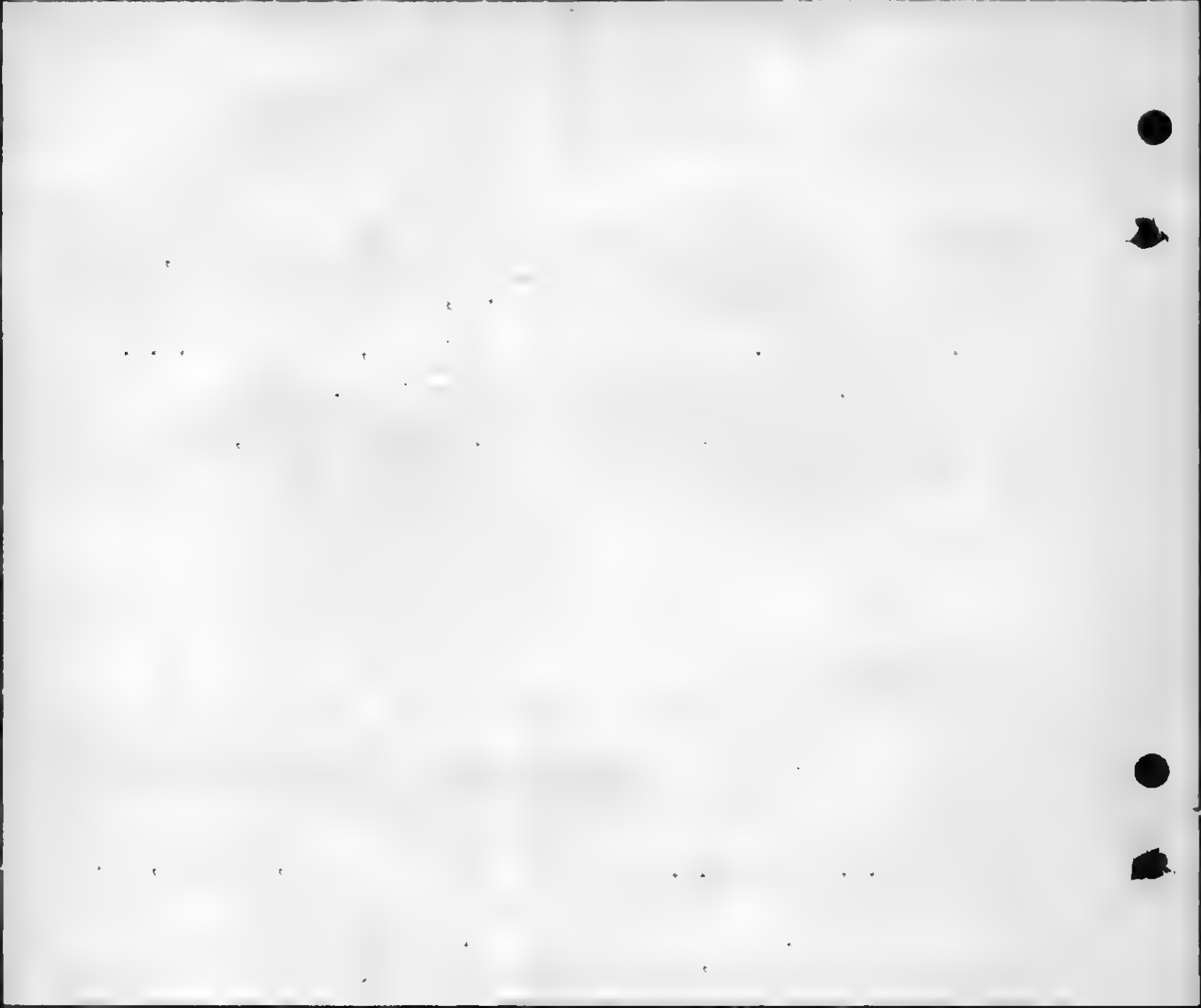
MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐



# 1 Page 4 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. TELEPHONE: 3-1111 Baltimore, Md. Bel Air, Md. 1 VS A15 (4) 15M 10/57 3176 03163 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY Harford MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air (Rural) c. LENGTH OF STAY IN 1b 1 year c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air (Rural) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Chatham Place d. STREET ADDRESS 102 Chatham Place e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Last Maxwell Carl Newman 4. DATE OF DEATH Month Day Year March 31, 19 61 5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Nov. 1, 1885 9. AGE (In years birth day) yrs. 75 IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Hull Const. 10b. KIND OF BUSINESS OR INDUSTRY Steel-Shipyard 11. BIRTHPLACE (State or foreign country) Wilmington, Delaware 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Henry H. Newman 14. MOTHER'S MAIDEN NAME Katherine C. Heinz 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 216-10-4120 17. INFORMANT (Son) Henry C. Newman 102 Chatham Place Bel Air, Maryland 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION (b) CORONARY SCLEROSIS (c) ARTERIO SCLEROSIS, ADVANCED INTERVAL BETWEEN ONSET AND DEATH 1/2 HR. 3 MO 2 YRS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☐ of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from APR. 1960 to MAR 31, 1961, that I last saw the deceased alive on 15 MAR 19 61, and that death occurred at 11:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2 Apr 61 ACTUAL SIGNATURE H. P. Sidwell M.D. PHYSICIAN'S NAME (Type) H. P. Sidwell M.D. Franklin Street, Bel Air, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/3/61 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Broadway & Williams ST. Bel Air, Maryland 24a. REC'D BY REGISTRAR DATE APR 3 61 24b. REGISTRAR'S SIGNATURE



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3177

## CERTIFICATE OF DEATH

03164

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Hartford</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u> c. LENGTH OF STAY in lb <u>6 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution, Residence before admission)<br>a. STATE <u>Kansas</u> b. COUNTY <u>1</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scott City</u><br>d. STREET ADDRESS <u>54x-5</u> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>George Graham Nonnamaker</u>   |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>3</u> Day <u>11</u> Year <u>1961</u>  |  |  |  |
| <b>5. SEX</b><br><u>Male</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>July 8 1889</u>   |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Riding School Owner</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Indiana</u>   |  | <b>9. AGE</b> (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>11</u> Hours <u>19</u> Min.  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>Frank Nonnamaker</u>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Agony Litzemberger</u>  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>George Nonnamaker</u>  |  |  |  |
| <b>17. INFORMANT</b><br><u>George Nonnamaker</u>  |  |  |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u><br>DUE TO (b) <u>42</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>42</u><br>DUE TO (c) <u>42</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |   |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. <u>19</u> p.m.  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <b>20f. (City or town)</b>  |  | <b>(County)</b>  |  | <b>(State)</b>  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 1, 1961</u> <b>to</b> <u>March 11, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 11, 1961</u> , <b>and that death occurred at</b> <u>5 P.M.</u> <b>from the causes and on the date stated above</b>   |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Dualey Phillips</u> M.D.  |  |  |  |   |  |  |  |
| <b>22b. DATE SIGNED</b><br><u>March 11, 1961</u>  |  |  |  |   |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Dualey Phillips</u>   |  |  |  |   |  |  |  |
| <b>22d. ADDRESS</b><br><u>Hartford, Indiana</u>   |  |  |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b>  |  | <b>23b. DATE THEREOF</b><br><u>March 12, 1961</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Scott City</u>  |  |  |  |
| <b>23d. LOCATION (City, town or county)</b><br><u>Kansas</u>  |  | <b>(State)</b>   |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>A &amp; Bailey</u>  |  |  |  |
| <b>24. ADDRESS</b><br><u>Hartford, Indiana</u>  |  | <b>25a. RECEIVED BY REGISTRAR</b><br><u>Mar 15 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kraus</u>   |  |  |  |

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# 3178 **MARYLAND STATE DEPARTMENT OF HEALTH** **DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND** **CERTIFICATE OF DEATH**

03165

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Harford</i>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <i>md</i> b. COUNTY <i>Harford</i> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Harre-de-Grace</i>  |  | c. LENGTH OF STAY IN 1b<br><i>13 hrs.</i>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Harford Memorial Hospital</i>   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Cibingdon</i>                                 |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <i>Baby</i> Middle <i>GIRL</i> Last <i>Peaker</i>  |  | 4. DATE OF DEATH<br>Month <i>3</i> Day <i>31</i> Year <i>1961</i>  |  |
| 5. SEX <i>Female</i>   |  | 6. COLOR OR RACE <i>Negro</i>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><i>3-31-61</i>   |  |
| 9. AGE (In years last birthday)<br><i>13</i>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>HARFORD CO. MARYLAND</i>   |  | 12. CITIZEN OF WHAT COUNTRY  |  |
| 13. FATHER'S NAME<br><i>Lewis W. Jackson</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Daisy Parker</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO. 17. INFORMANT Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary atelectasis</i><br>DUE TO (b) <i>Immaturity</i><br>DUE TO (c) <i>Premature labor</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <i>none</i> |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <i>19</i>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                            |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from... 19... to... 19..., that (I) (we) last saw the deceased alive on... 19... and that death occurred at <i>12:30</i> M., from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE<br><i>Wm. M. Keen</i>   |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type)   |  | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>CREMATION</i>  |  | 23b. DATE THEREOF<br><i>4-1-61</i>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Harford Memorial Hosp</i>   |  | 23d. LOCATION (City, town or county) (State)<br><i>Harre de Grace, Md</i>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>Harry A. Zully</i>  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>APR 7 '61</i>   |  |
| 25b. REG. STRAR'S SIGNATURE<br><i>Arthur S. Kline</i>  |  |  |  |



1  
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03166

|   |                           |   |  |   |   |
|---|---------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u>   |                           |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Harford</u> |   |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Normansville</u>  |                           |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Normansville</u>                                 |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |                           |   | d. STREET ADDRESS <u>Island Branch Road</u>  |   |   |
| 3. NAME OF DECEASED (Type or print) <u>Claude S. Price</u>  |                           |   | 4. DATE OF DEATH <u>March 23</u> 19 <u>61</u>  |   |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>SEPT. 15, 1904</u>   | 9. AGE (In years last birthday) <u>56</u> yrs.  | 10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>                             |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                           | 13. FATHER'S NAME <u>JEFF PRICE</u>   |  |   |   |
| 14. MOTHER'S MAIDEN NAME <u>JOSSIE ST JOHN</u>  |                           | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)   |  |   |   |
| 16. SOCIAL SECURITY NO. <u>214-18-1068</u>  |                           | 17. INFORMANT <u>Mrs. Healy Allen, 7400 Route 1</u> Address   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>(a) IMMEDIATE CAUSE (a) <u>G S W Cerebrum</u><br>976X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) }<br>(a), stating the underlying cause last. (c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Interval between onset and death</u> |                           |   |  |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shotgun</u>  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year <u>4:30 a.m. 3-23-61</u>   |                           | 20d. INJURY OCCURRED <u>at work</u> <input type="checkbox"/> <u>Not at work</u> <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>    |   |
| 20f. (City or town) <u>Normansville</u> (County) <u>Harford</u> (State) <u>MD</u>   |                           | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u>   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/> BELAIR, MD  |  |   |   |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>  |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-23-61</u>  |  |   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                           | Address (Street, city, town, or county)   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 22b. DATE THEREOF <u>3-25-61</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEM. GARDENS BELAIR HARFORD CO., MD.</u> |   |
| 22d. LOCATION (City, town, or country) <u>Belair</u> (State) <u>MD</u>  |                           | 23. FUNERAL DIRECTOR <u>Norman W. Crisburn, 5100 Route 1</u> ADDRESS  |  |   |   |
| 24a. REC'D BY REGISTRAR <u>27</u>   |                           | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>  |  |   |   |

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3180

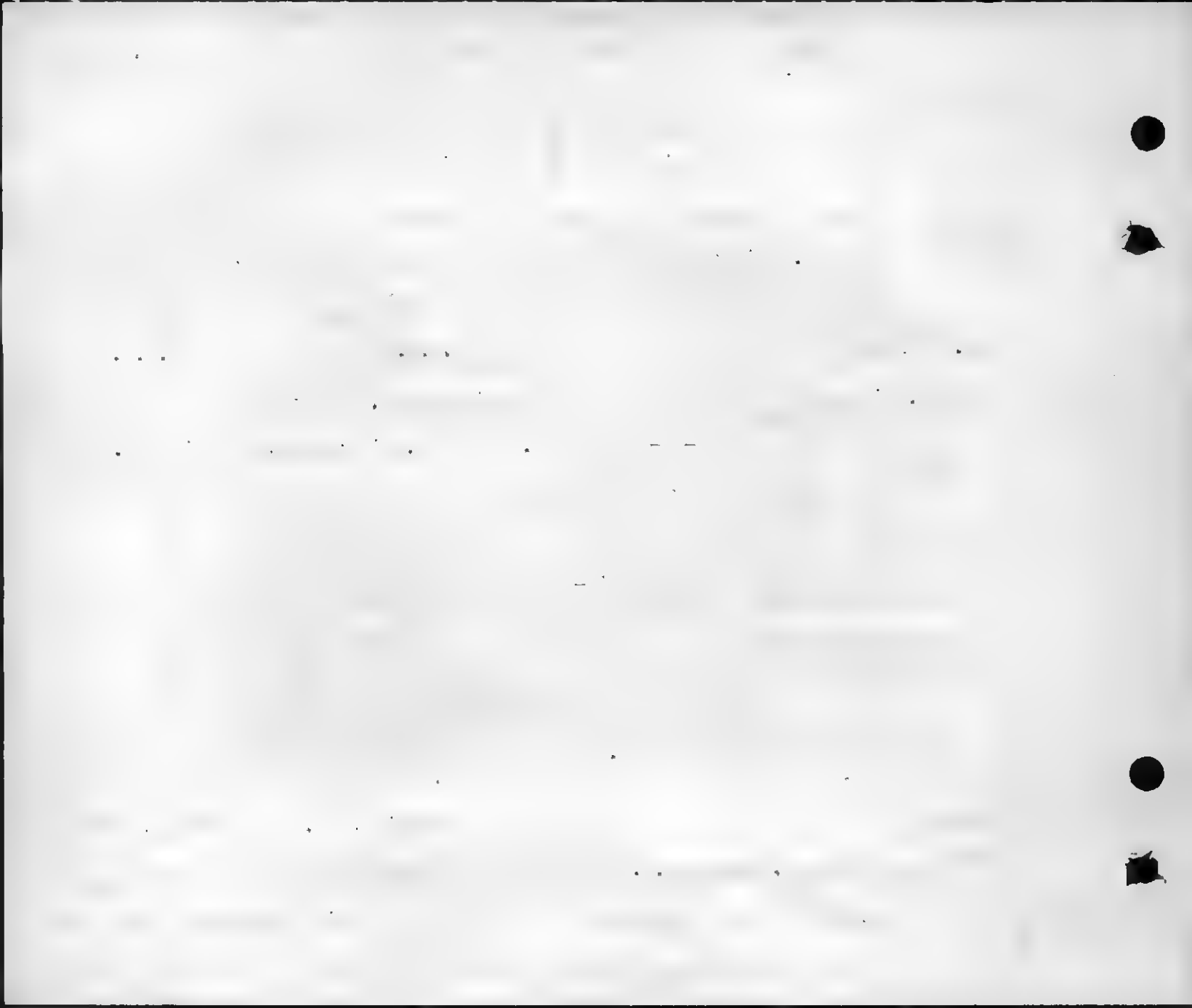
## CERTIFICATE OF DEATH <sup>4 transcripts</sup>

Reg. Dist. No. 03167

|   |                                  |   |  |  |  |   |  |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> <b>MARYLAND</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air</b>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bel Air</b>   |  |   |  |
| c. LENGTH OF STAY IN 1b<br><b>Life</b>  |                                  |   |  | d. STREET ADDRESS<br><b>Vale Road</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Vale Road</b>   |                                  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James J.</b> Middle <b>Richardson</b> Last <b></b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>9</b> Year <b>1961</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 8, 1901</b> | 9. AGE (In years last birthday)<br><b>59</b> yrs   | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b> | IF UNDER 24 HRS<br>Hours <b></b> Min. <b></b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Reg. Pharmacist</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Drug</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John S. Richardson</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth K. Hardesty</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>215-05-0773</b>   |  | 17. INFORMANT<br><b>Mrs. Martha E. Richardson, Bel Air, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b><br>DUE TO<br>(c) <b>Chronic Cardio-vascular Disease</b> |                                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hours</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Emphysema</b>  |                                  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <b>11</b> p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town)   |  | (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>Jan. 8, 1960</b> , to <b>March 9, 1961</b> , that I last saw the deceased alive on <b>March 9, 1961</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.   |                                  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Willard P. Hudson</b>  |                                  | M.D. <b>Forest Hill, Md.</b>  |  | DATE SIGNED<br><b>March 10, 1961</b>   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Willard P. Hudson, M.D.</b>   |                                  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>3/12/1961</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Spring</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Bel Air Maryland</b>                                  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph W. Foster</b><br><b>W. Broadway &amp; Williams St. Bel Air, Maryland</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>MAR 13 '61</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>C. H. S. Hays</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the attending physician. The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, to FURNISH TO THE REGISTRAR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOSTER FUNERAL HOME  
W. BROADWAY & WILLIAMS  
BEL AIR, MD.



## CERTIFICATE OF DEATH

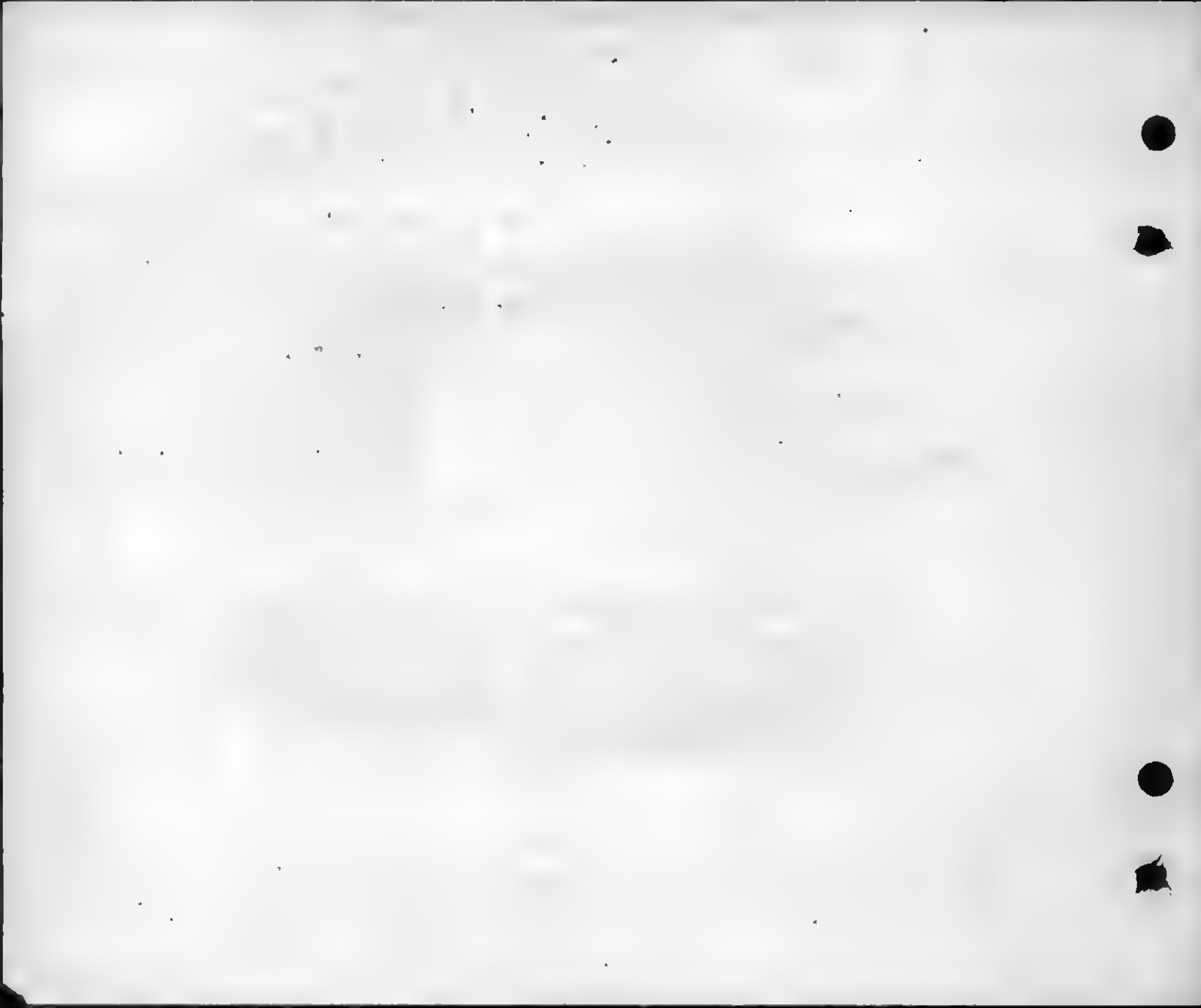
Reg. Dist. No. 03168

3181

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural-Whiteford</b>  |   | c. LENGTH OF STAY IN 1b<br><b>11 mo.</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Little Road</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>JAMES FRANKLIN SIMPERS</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>March 15, 19 61</b>   |  |
| 5 SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 23, 1960</b> |
| 9. AGE (In years last birthday) yrs<br><b>11</b>  |   | 10. IF UNDER 1 YEAR: Months Days Hours Min.<br><b>11</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>-----  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Harford Co., Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Allen R. Simperts</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Myrtle Combs</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>-- -- --   |   | 16. SOCIAL SECURITY NO<br>-----  |  |
| 17. INFORMANT<br><b>Allen R. Simperts, Whiteford, Md.</b>   |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)     |
| 21. I certify that I attended the deceased from <b>March 14, 1961</b> to <b>March 15, 1961</b> , that I last saw the deceased alive on <b>March 14, 1961</b> , and that death occurred at <b>12 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Delta, Penna.</b> DATE SIGNED <b>3/15/61</b>   |   |  |  |
| ACTUAL SIGNATURE <b>Josiah A. Hunt</b> M.D.   |   | PHYSICIAN'S NAME (Type) <b>Josiah A. Hunt</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 22b. DATE THEREOF<br><b>Mar. 18, 1961</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fellowship</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Pylesville, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. Harkin</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 17 '61</b>  |  |
| ADDRESS<br><b>Delta, Penna.</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Huns</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be obtained by a hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3182

Item 14 Film G204 4/6/61 1wk

CERTIFICATE OF DEATH

03169

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u><br>c. LENGTH OF STAY IN 1b <u>1 hr 15 min</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u><br>b. COUNTY <u>HARFORD</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u><br>d. STREET ADDRESS <u>1</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>First <u>EMORY</u> Middle <u>THOMAS</u> Last <u>SMITHSON</u><br>5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JAN. 6, 1880</u> 9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS. at birthday) <u>81</u> yrs. Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>                                    |  | 4. DATE OF DEATH<br>Month <u>MARCH</u> Day <u>26</u> Year <u>1961</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>None</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>HARFORD CO., MD.</u><br>12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  |  |
| 13. FATHER'S NAME <u>THOMAS SMITHSON</u><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u><br>16. SOCIAL SECURITY NO. <u>197-07-2932</u>   |  | 14. MOTHER'S MAIDEN NAME <u>unknown</u><br>17. INFORMANT <u>MRS. CHARLES MICHAEL, BELAIR, MD.</u><br>Address <u></u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br><u>120.1</u> DUE TO (b) <u>due to coronary thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>A.S.C. v.D.</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>                 |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)<br>20c. TIME OF INJURY Month, Day, Year <u>3/26</u> 19 <u>61</u><br>Hour a.m. <u></u> p.m. <u>19</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.) <u></u><br>20f. (City or town) <u></u> (County) <u></u> (State) <u></u> |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/26</u> 19 <u>61</u> to <u>3/26</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>MARCH 26, 1961</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.  |  | 22a. SIGNATURE <u>Edward C. Loo, M.D.</u> M.D. 22b. DATE SIGNED <u>3/27/61</u><br>22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u> 22d. ADDRESS <u>211 N. Union Ave. Harford, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u><br>23b. DATE THEREOF <u>3-29-61</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>SLATEVILLE</u><br>23d. LOCATION (City, town or county) <u>DELTA, PA.</u> (State) <u>Pa.</u>   |  | 25a. REC'D BY REGISTRAR <u>John H. Harkins, Delta, Pa.</u> DATE <u>APR 3 '61</u><br>25b. REGISTRAR'S SIGNATURE <u>Wm. S. Harkins</u>   |  |

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Mrs. Ingeborg Olsen 6824 Owlishead Court Brooklyn 20, N.Y.

3183

03170

|   |  |  |                                       |
|---|--|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Hartford</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>md</b> b. COUNTY <b>Hartford</b>                    |                                       |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hartford</b>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hartford</b>   |                                       |
| c. LENGTH OF STAY IN b. <b>7 days</b>   |  | d. STREET ADDRESS <b>6824 Owlishead Court</b>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Hartford Memorial Hospital</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Charles W. Thompson</b>  |  | 4. DATE OF DEATH <b>March 3, 1961</b>  |                                       |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Nov. 8, 1885</b>  |
| 9. AGE (in years last birthday) <b>75 yrs.</b>  |  | 10. IF UNDER 1 YEAR Months <b>3</b> Days <b>8</b> Hours <b>19</b> Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>   |                                       |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Sweden</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                       |
| 13. FATHER'S NAME <b>Thomas Uidal</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Ingeborg Unknown</b>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  | 16. SOCIAL SECURITY NO. <b>085-10-3370</b>   |                                       |
| 17. INFORMANT <b>Arthur L. Thoma</b>  |  | Address <b>6824 Owlishead Court Brooklyn 20, N.Y.</b>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |  |                                       |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Sarcoma, metastatic lungs</b>   |  |  |                                       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sarcoma - primary site undetermined</b>   |  |  |                                       |
| (c) <b>Solar Pneumonia, rt</b>  |  |  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>   |  |  |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>   |  |  |                                       |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |                                       |
| 20c. TIME OF INJURY Month, Day, Year <b>April 18, 1950</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>   | 20f. (City or town) <b>March 1961</b> |
| (County) (State)  |  |  |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>March 1961</b> to <b>March 1961</b> , that (I) (we) last saw the deceased alive on <b>March 1961</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above. |  |  |                                       |
| 22a. SIGNATURE <b>Ralph Horkey</b>  |  | 22b. DATE SIGNED <b>March 7, 1961</b>  |                                       |
| 22c. PHYSICIAN'S NAME (Type) <b>Ralph Horkey</b>  |  | 22d. ADDRESS <b>Churchville Md</b>   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>Mar. 11, 1961</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>  |  | 23d. LOCATION (City, town or county) <b>Bel Air, Hartford Co., Maryland</b>  |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b>  |  | 25. REC'D BY REGISTRAR <b>MAR 13 '61</b>   |                                       |
| ADDRESS <b>W. Broadway + Williams St Bel Air, Maryland</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoma</b>  |                                       |

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

W. BROADWAY + WILLIAMS BEL AIR, MD.



TO DELIVER TO THE MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3184

03171

|  |                              |   |   |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Harford</u>  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Harford</u>                        |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Havre de Grace</u>  |                              | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Havre de Grace</u>   |   |
| c. LENGTH OF STAY IN 1b<br><u>14 DAYS</u>  |                              | d. STREET ADDRESS<br><u>Chapel Road</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Harford Memorial Hospital</u>   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>William Thompson</u>  |                              | 4. DATE OF DEATH<br>Month Day Year<br><u>March 16 1961</u>  |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 8, 1931</u> |
| 9. AGE (In years last birthday)<br><u>29</u> yrs.  |                              | 10. IF UNDER 1 YEAR<br>Months Days<br><u>29</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>NOTE SALESMAN</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>SEAL TEST</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>MD</u>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>MILLARD H. THOMPSON</u>  |                              | 14. MOTHER'S MAIDEN NAME<br><u>ROSA BRADFORD</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>218-32-0585</u>   |   |
| 17. INFORMANT<br><u>DORRIS J. THOMPSON</u>   |                              | Address<br><u>HAVRE DE GRACE R.D. 2 MD</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u><br>104.7<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Phlebotrombosis R leg + thigh</u><br>DUE TO (c) <u>Fracture R fibula + Rupture ligaments R ankle</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Fell carrying case milk</u> |                              |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                              |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><u>Fell carrying case milk</u>                              |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>  |                              | 20f. (City or town) (County) (State)<br><u>Harford Co. MD</u>   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                              |   |   |
| ACTUAL SIGNATURE<br><u>Gerald P Palmer</u>   |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u>  |   |
| EXAMINER'S NAME (Type)<br><u>Gerald P Palmer MD</u>  |                              | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                              | DATE SIGNED<br><u>3-17-61</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                              | 22b. DATE THEREOF<br><u>MAR. 19 1961</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>WESLEYAN CHAPEL</u>   |                              | 22d. LOCATION (City, town, or country) (State)<br><u>HARFORD CO. MD</u>   |   |
| 23. FUNERAL DIRECTOR<br><u>A. Madison Mitchell</u>   |                              | ADDRESS<br><u>Havre de Grace MD.</u>  |   |
| 24a. REC'D BY REGISTRAR<br><u>Arthur S. Kraus</u>  |                              | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |   |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 03172

3185

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>HARFORD</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BELAIR</u>  |                                  | c. LENGTH OF STAY IN 1b  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>HAZEL S. WEBB</u>   |                                  | 4. DATE OF DEATH Month Day Year<br><u>3-29-1961</u>  |  |
| 5. SEX <u>F.</u>  | 6. COLOR OR RACE <u>W.</u>       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 16, 1891</u>   |
| 9. AGE (In years last birthday) <u>69</u> yrs   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>   |  |
| 13. FATHER'S NAME <u>WILLIAM SMITH</u>  |                                  | 14. MOTHER'S MAIDEN NAME <u>MATTIE BOYLE</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  |
| 17. INFORMANT Address<br><u>Joseph H Webb Bel Air Rd #1, End.</u>   |                                  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO <u>260X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Arterio-sclerotic C.V. Disease with Hypertension</u><br>(c) <u>Decadent Nutrition</u> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hrs</u><br><u>8 yrs</u><br><u>18 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Arteriosclerosis</u>  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Sept 1940</u> to <u>March 1961</u> , that I last saw the deceased alive on <u>March 29, 1961</u> and that death occurred at <u>6:01 AM</u> , from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <u>J. Ralph Horkey</u> M.D.  |                                  | ADDRESS (Street, city or town, state) <u>Churchville Md</u> DATE SIGNED <u>3/29/61</u>   |  |
| PHYSICIAN'S NAME (Type) <u>J. Ralph Horkey MD</u>   |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 22b. DATE THEREOF <u>3-31-61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>FAWN GROVE CEM.</u>  | 22d. LOCATION (City, town, or county) (State) <u>FAWN GROVE, YORK CO., Pa.</u>     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth C. Shum, Stewartstown Pa.</u>   |                                  | 24a. REC'D BY REGISTRAR <u>DATE APR 4 '61</u>  |  |
|   |                                  | 24b. REGISTRAR'S SIGNATURE <u>C. J. Shum</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3186

Items 1d, & 14 Film G284 4/6/61 iwk

03173

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural- Street

c. LENGTH OF STAY IN 1b

2 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address)

(Private home) of Paul Halsey, Jr.

3. NAME OF DECEASED (Type or print)

Raymond Philip Weiss

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

February 2, 1909 52 yrs.

9. AGE (In years last birthday)

March 25, 1961

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

10b. KIND OF BUSINESS OR INDUSTRY

Nashville, Ill.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Weiss

14. MOTHER'S MAIDEN NAME

Georgianna Beattie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

320-10-6160

17. INFORMANT

Mrs. Raymond Weiss, 1159 S. Grove Ave. Oak Park, Illinois.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Coronary Thrombosis  
Coronary insufficiency

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 hours

6 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Hour a.m.  
p.m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 25, 1961, to March 25, 1961, that (I) (we) last saw the deceased alive on March 25, 1961, and that death occurred at 6:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

Donald A. Hunt M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Donald A. Hunt M.D.

22d. ADDRESS

Delta, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE THEREOF

Mar. 26, 1961

23c. NAME OF CEMETERY OR CREMATORY

Delta, Penna.

23d. LOCATION (City, town or county)

Chicago, Illinois

24. FUNERAL DIRECTOR'S SIGNATURE

John H. Harkins

ADDRESS

25a. REC'D BY REGISTRAR

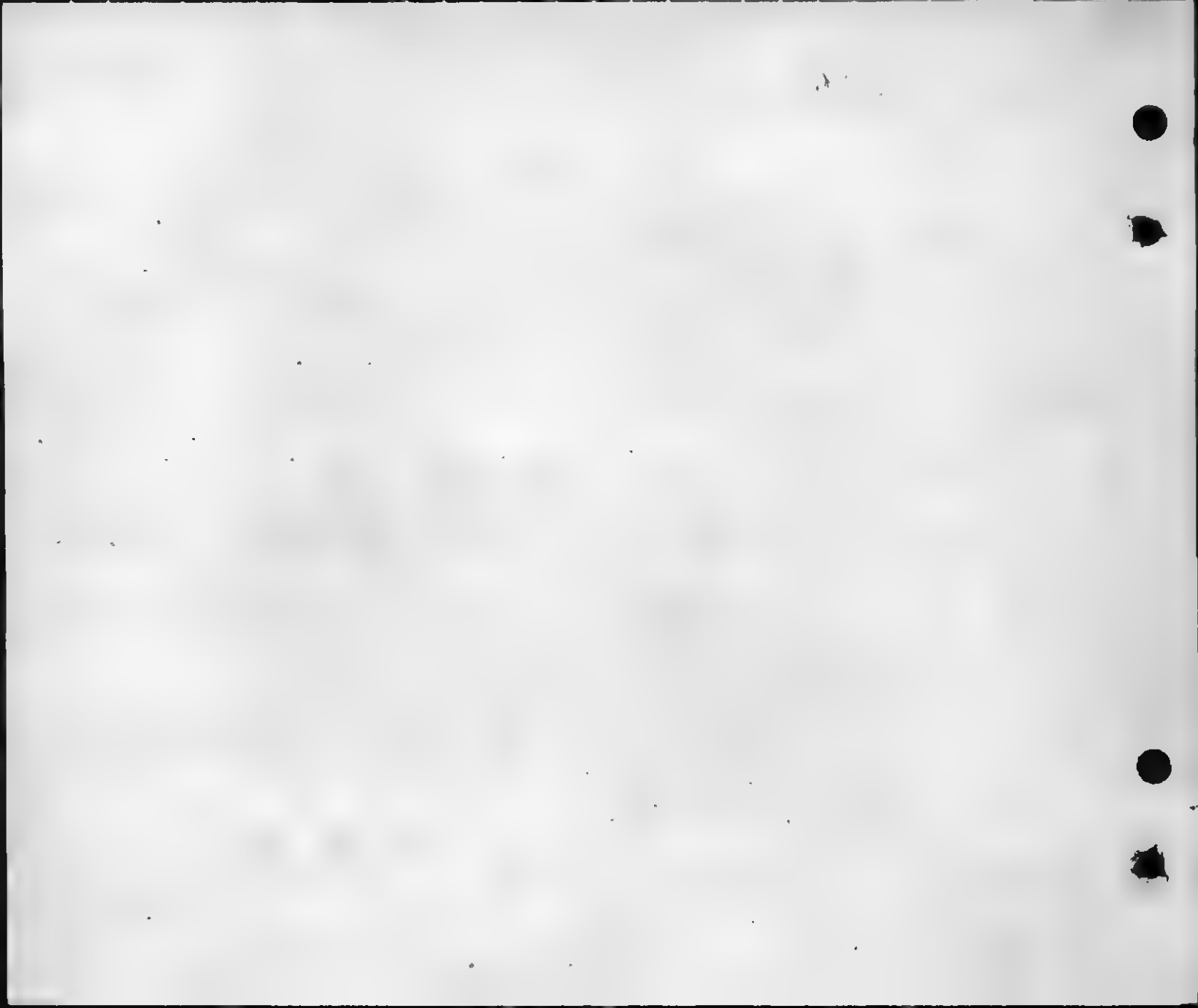
DATE

25b. REGISTRAR'S SIGNATURE

Carl S. Kaus

TO HOLD VALID OR BINDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3187

## CERTIFICATE OF DEATH

Reg. Dist. No. 03174

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Harford</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Pylesville</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Pylesville</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                     | d. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Neva</b> Middle <b>J.</b> Last <b>Whiteford</b>   |                                     | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>25</b> Year <b>1961</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 19, 1883</b>   |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.   |                                     | IF UNDER 1 YEAR<br>Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Harford Co., Md.</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Howard Streett</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Jane Campbell</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Mrs. Frank Linkous, Pylesville RD, Md.</b>  |                                     | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerosis</b><br>DUE TO (c) |                                     |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>March 20, 1961</b> to <b>March 25, 1961</b> , that I last saw the deceased alive on <b>March 24, 1961</b> , and that death occurred at <b>6 A M.</b> from the causes and on the date stated above.   |                                     |  |  |
| ACTUAL SIGNATURE <b>Edward W. Hyson</b> M.D.  |                                     | ADDRESS (Street, city or town, state) <b>Fawn Grove, Penna.</b> DATE SIGNED <b>3/25/61</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Edward W. Hyson</b>  |                                     | <b>Fawn Grove, Penna.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>3-28-61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fawn Grove Meth. Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Fawn Grove, York Co., Penna.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Kenneth W. Williams</b>  |                                     | ADDRESS<br><b>Stewartstown, Penna.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>MAR 28 '61</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hume</b>  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3188

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|   |                               |  |                                       |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>HARFORD</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>                     |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>  |                               | c. LENGTH OF STAY IN 1b <b>LIFE</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>552 REVOLUTION ST.</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Ella Ida Williams</b>  |                               | 4. DATE OF DEATH <b>Mar. 11 1961</b>   |                                       |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>BLACK</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>APR. 18, 1885</b> |
| 9. AGE (In years lost birthday) <b>75</b> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                       |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>  |                               | 12. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>   |                                       |
| 13. FATHER'S NAME <b>unk.</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>ELIZA BODELY</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>   |                               | 16. SOCIAL SECURITY NO. <b>—</b>   |                                       |
| 17. INFORMANT <b>GRAYSON P. WILLIAMS</b>  |                               | 18. ADDRESS <b>2006 N. BENTALOU, ST. BALTO. 16, MD</b>   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>442X Uremia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart disease</b><br>DUE TO (c) <b>Cardio-Renal Insufficiency</b> |                               | INTERVAL BETWEEN ONSET AND DEATH   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 10, 1960</b> to <b>March 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 10, 1961</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above.   |                               |  |                                       |
| 22a. SIGNATURE <b>George T. Stansbury</b>   |                               | 22b. DATE SIGNED <b>3/13/61</b>  |                                       |
| 22c. PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>   |                               | 22d. ADDRESS <b>569 Revolution St. Havre de Grace, Md</b>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                               | 23b. DATE THEREOF <b>MAR 14 1961</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <b>ST. JAMES CEM.</b>  |                               | 23d. LOCATION (City, town, or county) (State) <b>HAVRE DE GRACE MD</b>   |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b>   |                               | 25a. REC'D BY REGISTRAR <b>MAR 15 '61</b>  |                                       |
| ADDRESS <b>HAVRE DE GRACE MD</b>  |                               | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |                                       |

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UNITED STATES OF AMERICA

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